The Modern Hospital

JUNE 1959

Pictures of Strike Against Voluntary Hospitals in New York

News photos show pickets massed at hospital entrance, besieged administrator, volunteers on duty in kitchens and elevators and on nursing floors (page 63)

Hospitals Accept Uniform System of Pricing Services

This group of 94 hospitals in Southern California has agreed to abide by a new set of principles for establishing charges (page 65)

Refresher Courses Help Build Standby Supply of Staff Nurses

By offering refresher courses for inactive nurses, these hospitals have tapped a new supply of personnel, helped nurses now at work learn new technics (page 87)

Architect's rendering of the new Holy Cross Hospital, San Fernando, Calif. (see page 77)

Baptist Memorial Hospital, Jacksonville, Florida. Reynolds, Smith & Hills, architects and engineers, Jacksonville; Henry G. Dupree Co., general contractor, Jacksonville.

The modern way to control hospital air conditioning.

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The Modern Hospital

JUNE 1959 VOLUME 92, NO. 6

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The Modern Hospital

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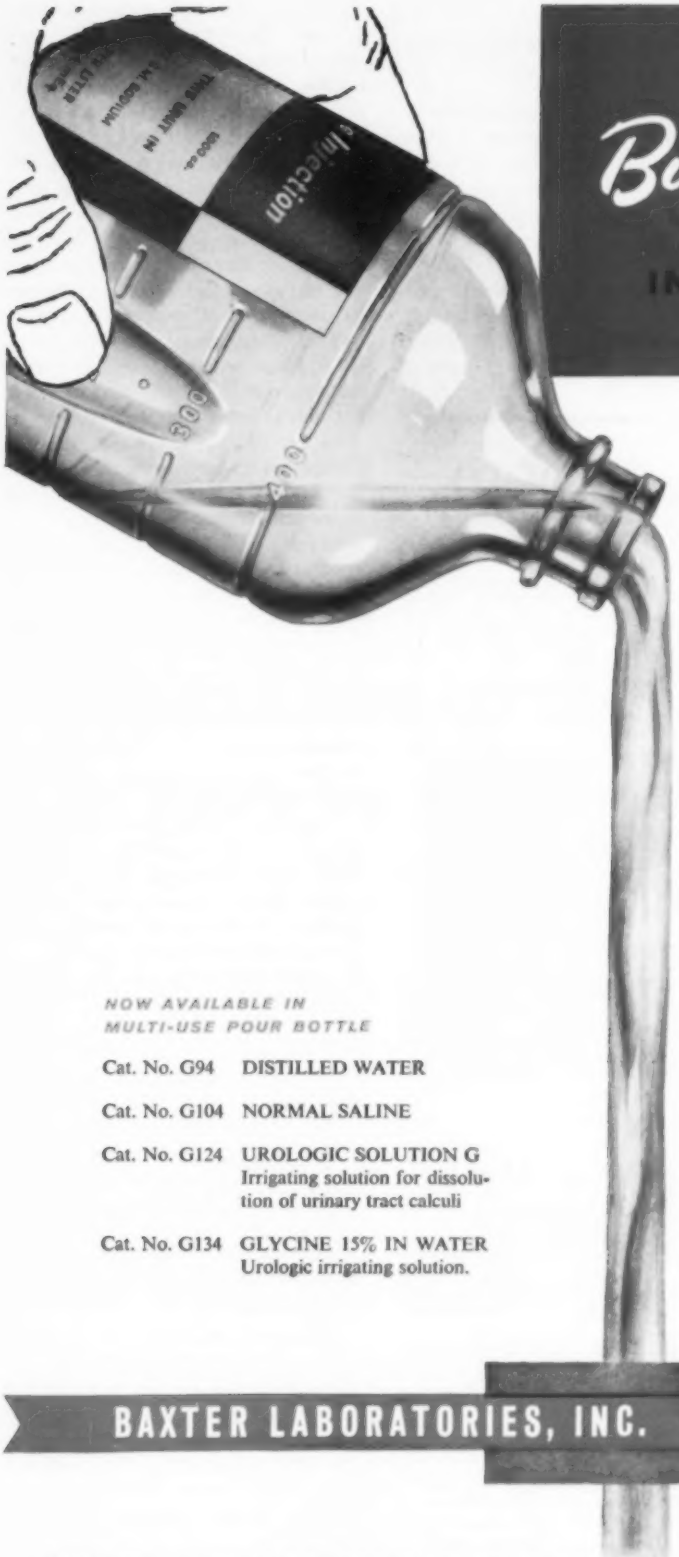

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READER OPINION

Partial Piping Didn't Work

Sirs:

Not often do I feel inclined to question recommendations of an article based upon such an obviously exhaustive study as that connected with your recently published article, "How Many Oxygen Outlets Are Enough?" (January issue) I was, however, amazed at and in complete disagreement with the recommendations. Seven years ago we opened a new general hospital of 135 beds with outlets in 20 per cent of the rooms. We faced our first disappointment – on the day we moved in – when we found that besides trying to fulfill patient requests for seven different types of rooms and segregating male and female patients, we also were faced with the task of matching patients needing oxygen with oxygen outlets. We gave up on the first day and proceeded to move cylinders all over the building just as we had been doing in our old hospital. About one year later, we put oxygen outlets in all other patient rooms and, in so doing, reduced our cost of oxygen to the extent that the installation paid for itself in less than two years – not taking into account labor savings. Our cylinder purchased oxygen had been nearly twice as costly as bulk purchased oxygen.

The safety advantages involved in doing away with all cylinders would justify an article within itself so I will not delve further into that matter.

In my opinion the same rationale should *not* be applied to the installation of a suction outlet in each room for several obvious reasons.

Moving patients from one room to another is a costly procedure. Not too many moves – the nonuser of oxygen away from the outlet in order to allow the user to get to the outlet – would be required to surpass the cost of an additional $50 outlet.

Another factor which should not be completely ignored is the psychology involved in whisking the patient off to a "special" room with oxygen.

Count me among those with a philosophy of "all or nothing at all," at least as far as oxygen piping is concerned. And I earnestly hope hospital planners, for the sake of everyone concerned, will avoid partial piping.

I earnestly feel that this article could influence some planners to make a very serious mistake in connection with oxygen piping and wonder if your publication would not be rendering a service by encouraging comment or articles from others.

E. B. Sledge
Administrator
Greenwood Leflore Hospital
Greenwood, Miss.

Based on Probable Need

Sirs:

When an architect or administrator is faced with the decision to provide any service in a patient's room (in this case oxygen outlets) he can approach the problem in two ways. He can, as Mr. Sledge indicated, put an outlet in each room or, in case of multiple bedded rooms, between each two beds.

The other approach would be to determine the need for the service and provide sufficient outlets to meet this anticipated need plus a considerable

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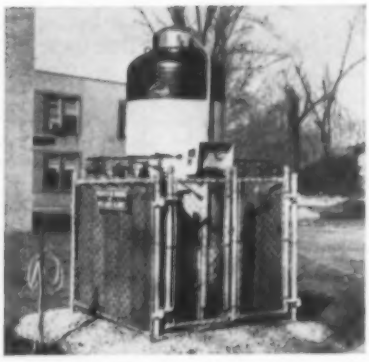
Surprisingly compact, this 90 VCC unit holds 90,000 cu. ft. of oxygen. It's a relatively small package because at atmospheric pressure liquid oxygen in its gaseous state would require 862 times more storage space.



One of the most popular storage units is LINDE's new AT-25. It holds 25,000 cu. ft. of oxygen, yet fits in an area only five feet square.

Both portable and compact, the LC-3 container can be moved about by one man—yet holds 3000 cu. ft. of oxygen, the same as 12 conventional cylinders. LC-3's can be used at the bedside or manifolded to provide a continuous supply to the piping system.

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safety factor. It was to this rational method that my paper was devoted.

A most useful criterion of need was expressed as the probability that any patient will require oxygen during his hospital stay. This criterion, it was found, varied between clinical services. The probability of a maternity patient's requiring oxygen was one out of 1325, in other words an extremely rare occurrence. Why plan for a probability of 1 to 1.8 as you would under the "all or nothing at all" formula?

Medical patients, on the other hand, required oxygen much more frequently, *i.e.* one out of every 4.7 medical patients required oxygen. Consequently, since patient movement is to be minimized, we concurred with the recommendations of Gaulin and Mr. Sledge. The experience on the surgical floors lay between these two extremes and any recommendation would depend on the weight assigned to the inconvenience of moving a patient from one room to another. Any recommendation should be viewed as an aid in "decision making," not as an absolute law engraved in stone forever. That is why we stated in the body of the article, "As for the surgical floors the hospital administrator can, with these two criteria, make a decision as to the necessity for 0.69 outlets per bed when the probability of having to move any one patient to an outlet – if the figure is lowered to 0.25 per bed – is 1 out of 69.

John D. Thompson
Research Associate
Yale University
Department of Public Health
New Haven, Conn.

Designed Peralta Unit

Sirs:

The March issue of The MODERN HOSPITAL had an article on the Peralta Intensive Care Unit.

We were the architects for this unit and spent considerable thought in its development and execution. No mention of us was made in the article.

Generally your magazine gives architectural credit to published plans and photographs. We hope you can correct this omission.

Stone, Marraccini & Patterson
San Francisco

The omission was indeed our error, for which we apologize. – ED.

Say It Out Loud

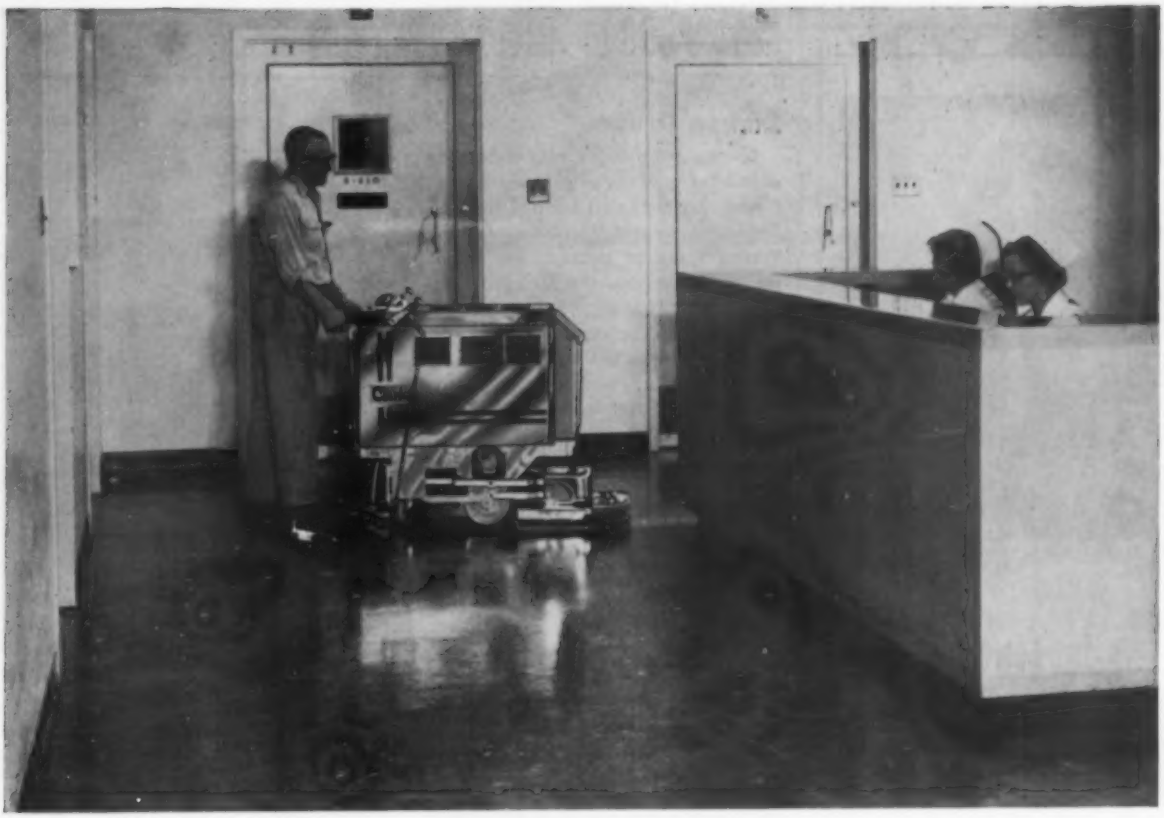
Sirs:

The article in The MODERN HOSPITAL, March 1959, *p.* 100, by David E. Rose and Mildred E. Schwier was very helpful to all of us. We have full accreditation and have no gripes, but one hears constantly of the misunderstanding that exists among hospital administrators concerning accreditation.

Instead of speaking about what National League for Nursing requires for this or that, the emphasis should be on what is required to administer a worthy educational program which we owe to students. There are ways of doing it, once we become aware of our own responsibility and cease to blame others for requiring what we ourselves should have judged necessary.

It is good to see us reach the point where we can talk *to each* other about this rather than *about each* other. Agreement or understanding is never reached until we reach the "talk to" stage. The article will help a great deal in this direction.

Sister Mary Anthony, R.N., Ed.M.
Director of Nursing
St. Margaret's Hospital
Kansas City, Kan.



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In the meantime, write for details about the Clarke-A-matic, just one of many different Clarke Floor Machines all designed and built to give you *clean* floors for dimes instead of dollars.

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ROVING REPORTER

Dial an Order

Nurses can dial the proper bedside orders for patients with a new device now being marketed for hospital use. This solution to the problem of maintaining standard patient care orders was developed and designed by a hospital administrator.

Donald C. Carner, administrator of Seaside Memorial Hospital, Long Beach, Calif., was bothered by the fact that patient care instructions, scrawled on scrap paper, were pasted to beds, doors and walls with adhesive tape. Besides looking untidy, such instructions were often overlooked.

"It occurred to me that the standard patient care orders might be mounted on cylinders so that the

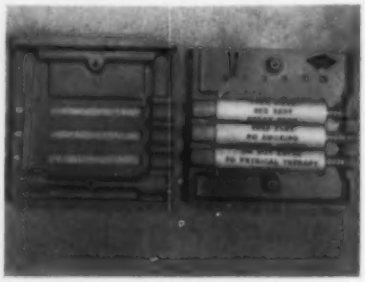
Nurse dials a patient's orders on the holder. Card at bottom provides space for any special instructions.

nurse, aide or orderly could simply dial the proper instruction near the bedside," he reports.

Although printed cards to fit into a card holder attached to the bed are available, Mr. Carner found that his system eliminates trips to and from the nursing station to obtain and post the cards and saves money by eliminating an inventory of the printed cards.

In his hospital, Mr. Carner found that the use of the wrist band patient identification system made it possible to move the standard instructions to the corridor wall, except in large wards where they are attached to the head of the bed. Mounted on the wall, the device prevents many unnecessary intrusions into the patient's room by aides, orderlies, technicians, dietitians and others.

"The patient thus obtains far more rest and privacy as he is not disturbed



Unassembled view shows how each cylinder provides space for several standard patient care instructions.

every time a hospital employe needs to check to see if this is the x-ray, blood test, special diet, or physical therapy case he is seeking," Mr. Carner says.

The device is made of fiber glass and has controls to prevent tampering with the instruction cylinders.

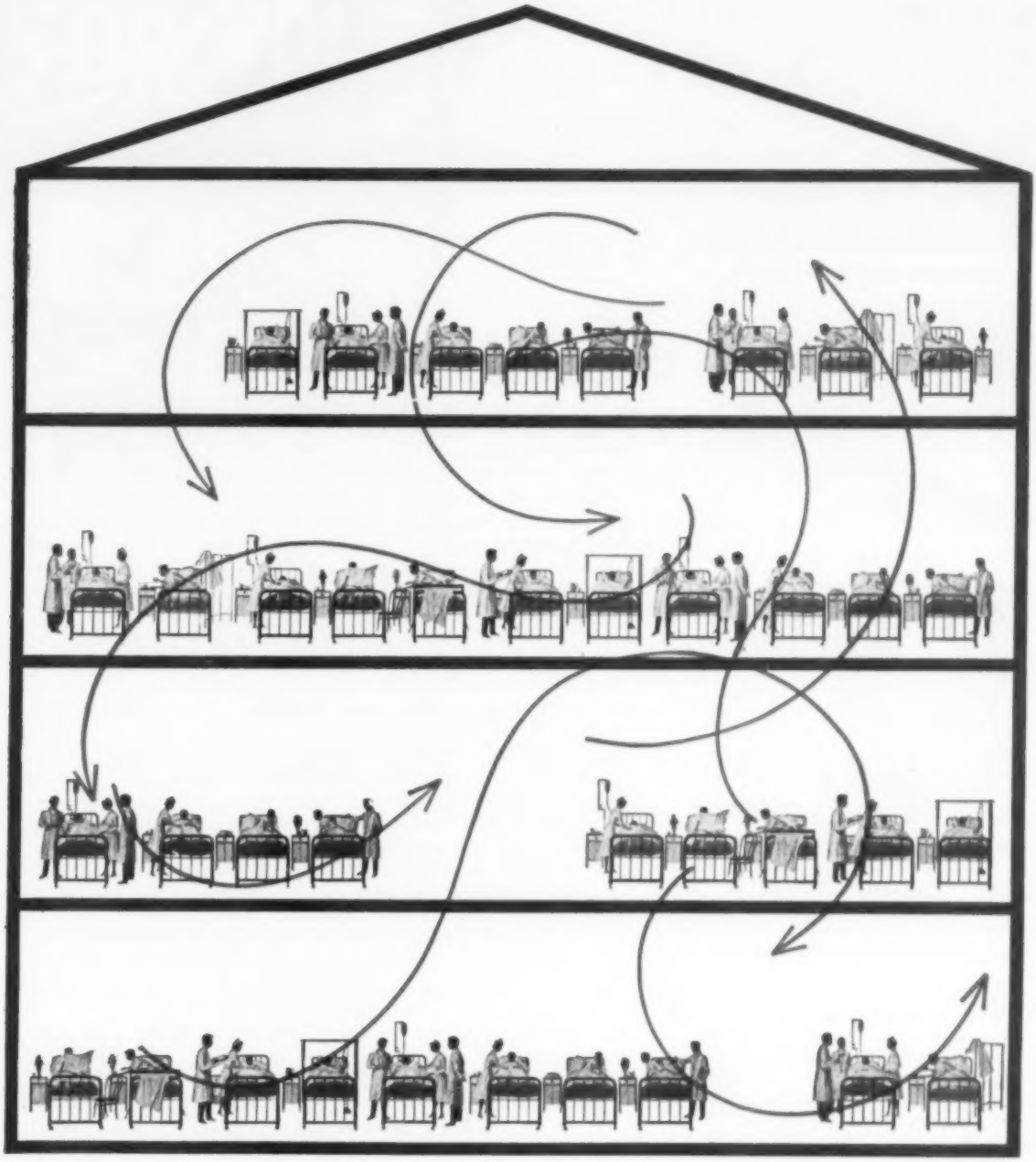
They Help One Another

A "big brother" system is being used by hospitalized veterans in their fight against mental illness. Recovering patients at the V.A. mental hospital at Salisbury, N.C., have formed a society known as "The Helping Hand," in which each member holds himself responsible for more seriously ill patients in hospital activities, the V.A. announced.

Dr. Samuel J. Muirhead, manager of the hospital, said the scheme has helped both members and nonmembers of the society.

More improved patients can help less fortunate patients toward recovery in ways that the hospital staff cannot, he said, since patients often notice improvement in the condition of their companions and thus become aware that their own improvement is possible.

The society is a select group with membership restricted to patients approved by its screening committee and elected by unanimous vote, Dr. Muirhead said.



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Does the Hospital's Size Influence the Character of Public Relations?

By Gordon Davis

Gordon Davis

JUST offhand and without giving too much thought to it, would you say that small hospitals tend naturally to have better public relations than large, or vice versa?

The easy answer to this one is to duck behind some convenient aphorism, such as "There is no grandeur in size," but the question is not asked idly. Certainly the size of your hospital has much to do with the nature of your program.

The large hospital has greater resources, greater capacity to employ specialized manpower for public relations functions. The administrator of the small hospital often has no help. If there is to be literature for patients, he must develop it. If there are to be press releases, he must write them himself.

Assuming that there is more than a shred of the gregarious in his makeup, however, the able administrator of a small hospital should be a happy person. He is close to the people he serves; he understands their passions and prejudices; he is sensitive to their moods; in turn his purposes should be better understood.

In fact, the need for organized public relations is partly the outgrowth of the communications failures that tend to develop with size. Bigness insulates. It interposes a protective string of subordinates between boss and consumers, lessening his exposure to their whims and reducing their comprehension of his motives.

Unless the head of the big institution undertakes specific compensatory measures, a situation can develop into an impasse before he is fully aware of it.

On the other hand, there are advantages in detachment, for it makes it easier to be objective, to resist expediency in favor of foresight. This, too, is important in public relations — or should I say it is important in public relations, too?

Choose your own illustrations. No doubt you know of a doubtful action into which a small hospital has been forced by the immediacy of public pressure but which a large hospital has resisted successfully. Perhaps you also know of instances in which a large hospital has seemed completely insensible to a public displeasure readily recognized and responded to by a small hospital.

Probably it is not safe to maintain that the administrator of a small hospital will profit most from strengthening his long-range public relations, the administrator of the large hospital from a closer look at what's happening in terms of public relations from day to day.

But at least it should be recognized that the size of the institution has an effect on both the philosophical approach to public relations and the suitability of given technic.

Can you develop activities that will bring to your hospital some of the public relations advantages that seem inherent to institutions of a different size? Of course you can. This essentially is the purpose behind public relations as a studied enterprise: the strengthening of communications weaknesses whether they arise from size or any other cause. ■

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*Carl W. Walter, M.D., "Aseptic Treatment of Wounds" (New York: The Macmillan Company, 1954), P. 172

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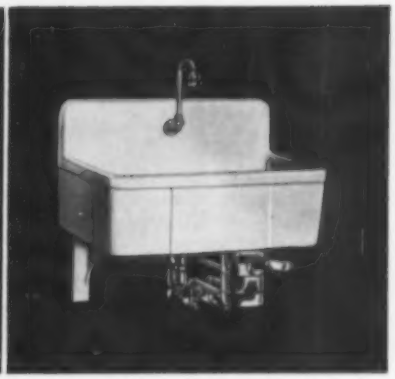

A goose-neck spout with Act-O-Matic spray helps to assure thorough cleanliness with this Crane *Duraclay* surgeon's sink.

Designed for comfortable patient posture, this Crane *Duraclay* sitz bath has a thermometer to check water temperature.

An elevated bubbler base provides maximum sanitation with this Crane *Waterfall* drinking fountain. Smart, modern design.

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TO THE NATION'S HOSPITALS

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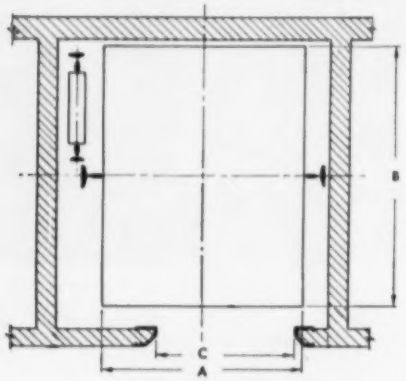
In neither case are the recommended dimensions nor load capacities adequate for today's hospital needs.

You can readily see why this is so in much of the equipment used daily by hospitals. For example—many hospital beds, with attachments, run over 8½' in length . . . an impossible "fit" in an 8' car. And some of the new, improved iron lungs are also too large for elevators designed according to present standards.

There are numerous other examples, of course, that make it clear present standards are inadequate. That is why Haughton engineers, when designing equipment for hospital elevator modernization or new construction, look beyond these standards—recommend equipment for today's hospital needs.

It will pay you to call on Haughton for vertical transportation that's a credit to your hospital . . . and a pattern for new hospital elevator standards most urgently needed.



HOSPITAL ELEVATOR STANDARDS RECOMMENDED BY HAUGHTON

LOAD	DIMENSIONS		
	A	B	C
4000 lbs.	5'4"	9'0"	4'
4500 lbs.	5'8"	9'6"	4'
5000 lbs.	6'0"	9'6"	4'

GET A PROPOSAL FROM HAUGHTON . . . for elevator modernization, installation, maintenance or service—62 Branch Offices to serve you.

Haughton Elevator Company

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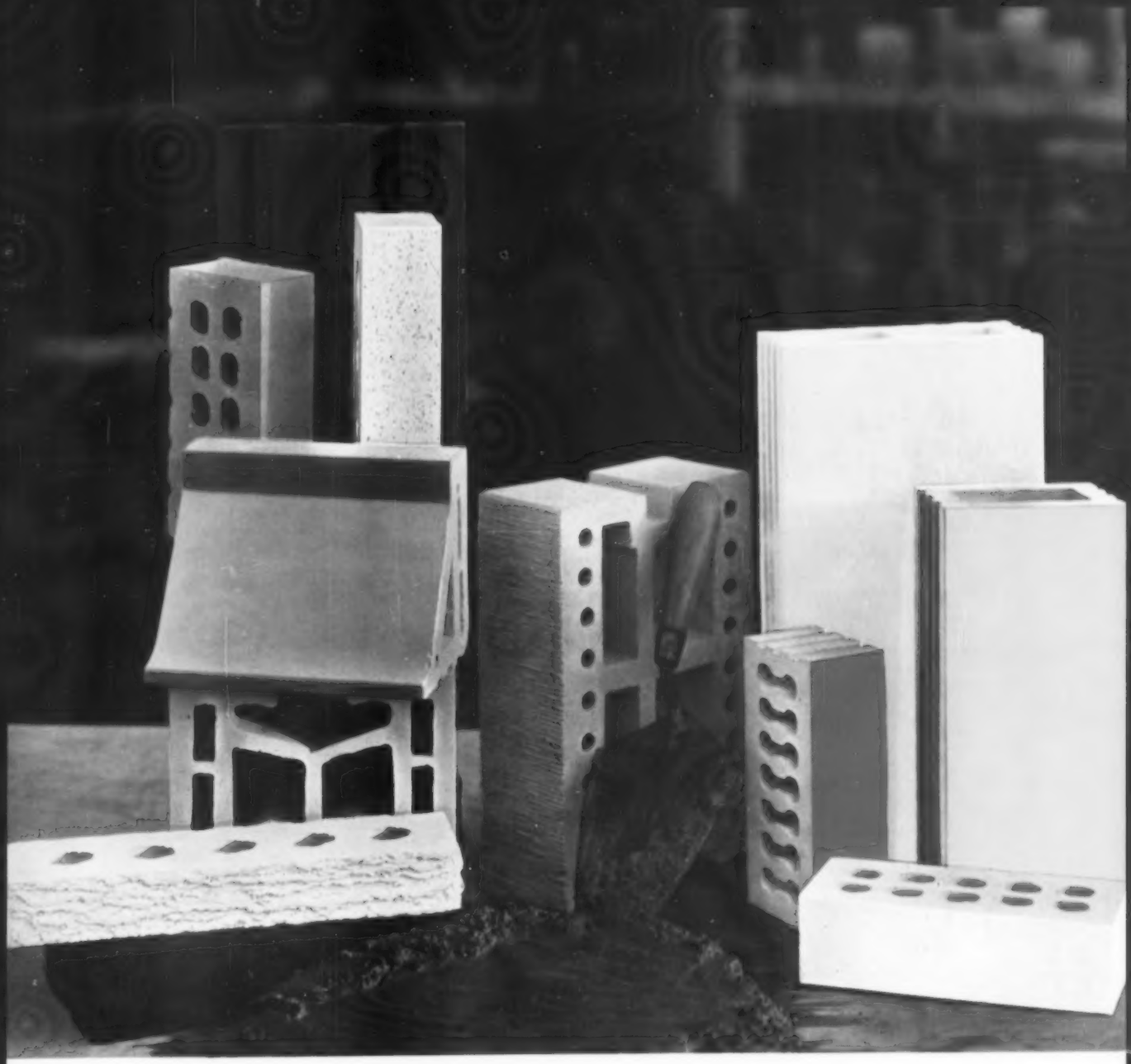

TODAY'S IDEA BECOMES TOMORROW'S SHOWPLACE

. . . when Natco structural clay products are in the picture

The photo above shows only a portion of the *complete* line of modern, colorful structural clay products manufactured by Natco . . . products designed for use in tomorrow's buildings. Shown are (1) Tex Dri-Wall tile, (2) Standard face brick, (3) Norman face brick, (4) Ceramic glaze Splayed Base, (5) Dri-Speedwall tile, (6) Wave-Tex roman face brick, (7) "SCR" brick, (8) Uniwall facing tile, (9) Ceramic glaze Vitribrik, (10) Ceramic glaze velour face brick, (11) "6T" Ceramic glaze Vitritile, and (12) "8W" Ceramic glaze Vitritile.

Write for one of our new, colorfully illustrated "full line" catalogs.

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What a boon to your Medical Records librarian! With Burroughs microfilming, patients' medical records can be filed in a hurry, found in a wink, preserved with scrupulous care. For here is microfilming at its economical best—equipped to record and read, file and find, protect and preserve these truly vital statistics.

LOOK AT THESE SPECIFIC ADVANTAGES:

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Find out what Burroughs microfilming can mean to your hospital. Phone our nearby office for details, or write Burroughs Division, Burroughs Corporation, Detroit 32, Michigan.

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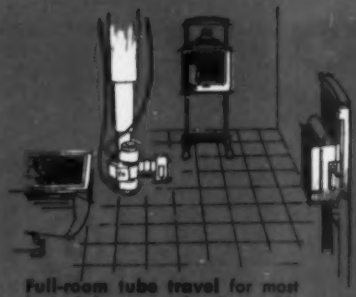
REGENT

Unobstructed table — easy passage all around . . . *ideal* for consultation viewing.

Draft-horse stamina — Regent is built to shoulder your heaviest x-ray schedules.

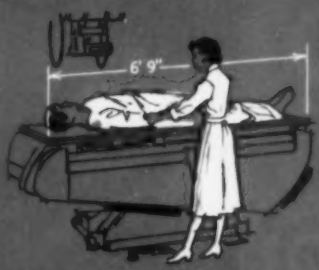


Full-room tube travel for most logical placement of radiographic apparatus.

Here's important news for all who demand top-qual in heavy-duty diagnostic x-ray apparatus

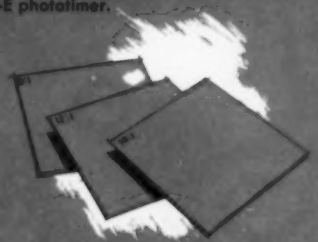
General Electric Regent gives you more all-round value per dollar invested in an island-table installation

Counterbalanced x-ray tube positions at a touch — no complicated motor drive.



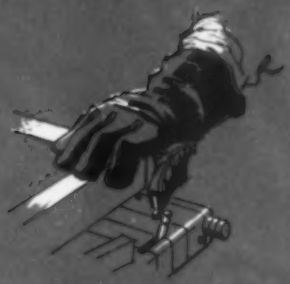
Roomy table top for patient comfort; simplifies positioning . . . reduces handling.

Super-Speed Reciprematic Bucky accepts interchangeable grids and G-E phototimer.



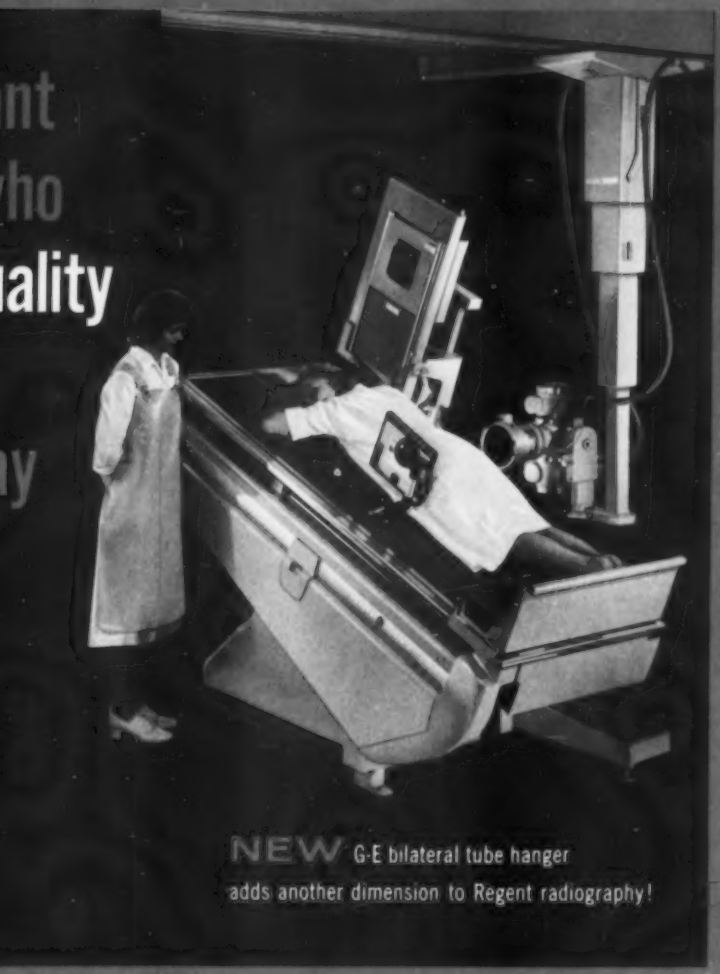
Bi-lateral tube hanger allows convenient cross-table radiography right from *front* of table . . . or rear, if desired.

Table tilts to 45° Trendelenburg — more than adequate for myelography, intravenous pyelography and gastro-intestinal studies.

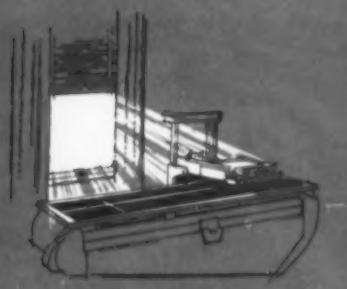


Hydraulic angulation, finger-tip controlled — response is fast, smooth and quiet.

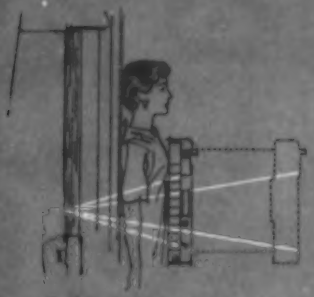
Automatic spot-film unit — a sturdy "featherweight" to lessen fatigue in fluoroscopy.



NEW G-E bilateral tube hanger adds another dimension to Regent radiography!



Spot-film phototimer has G-E sealed detector — unaffected by brightest room light.



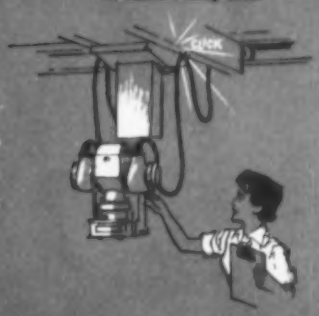
Full-screen viewing — with primary rays automatically confined to fluoroscopic-screen area.

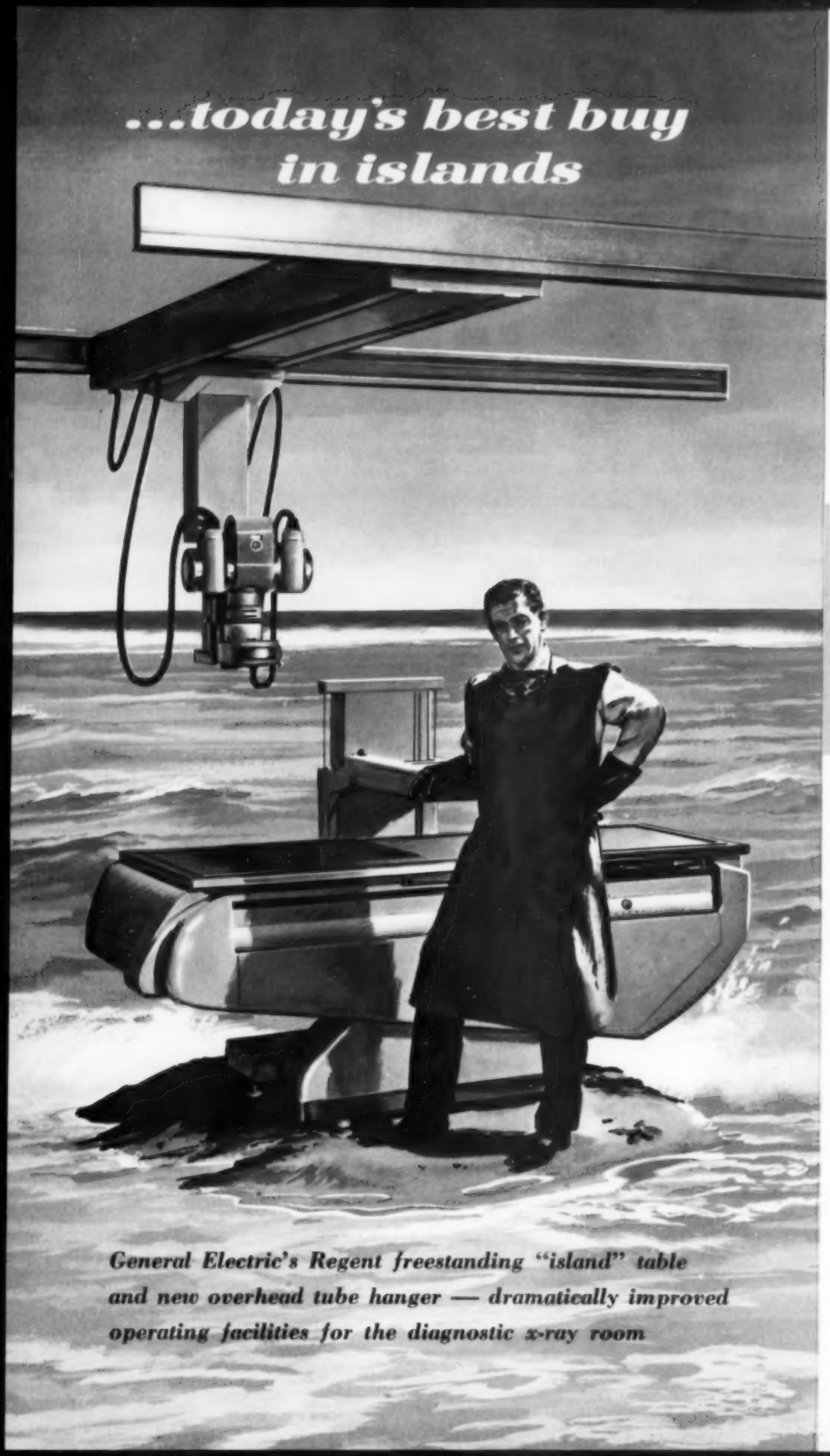
Fluoroscopic safety feature — panels close table slot when Bucky is parked at either end.

Extreme vertical range of tube hanger makes low-angle positioning easy.

No tugging or fiddling to aim radiographic tube, thanks to full universal movement.

Click signal tells correct alignment when centering tube hanger to table's long axis.





General Electric's Regent freestanding "island" table and new overhead tube hanger — dramatically improved operating facilities for the diagnostic x-ray room

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PLANNING THE HOSPITAL X-RAY DEPARTMENT

Planning and blueprinting a modern x-ray department are certain to involve the radiologist, the hospital administrator and the architect in a maze of complications. Logical starting point for any construction project involving x-ray facilities is your local General Electric x-ray consultant. Exploratory "shirt-sleeve" sessions with all persons involved first determine specific needs. Planning can then be expertly guided by our Installation Planning Service.

With your requirements in mind, this full-time staff of specialists considers every possible operating advantage and convenience: How to arrange equipment and make space work more profitably . . . power, wiring and protective requirements . . . plumbing and other arrangements are carefully analyzed. Thus the layout offered is based on the ultimate in service from the department's x-ray equipment.

Hospital architects rely on this General Electric service more and more because planning experience of more than 50 years helps G.E. provide hundreds of application advantages. Of course, there's no cost or obligation for this service.

You'll like doing business with General Electric

ng with General Electric offers plus values — extras that cost thing, yet count for so much. For stallation planning — the ability ange your equipment for peak nal efficiency. Also nationwide s to bring you a complete line plies, repair and parts service whenever needed. Technical literature and consultation with skilled engineer-specialists to aid in resolving special x-ray problems.

Still another plus — less apparent but no less significant — is the story told by the G-E nameplate on your apparatus. It's a badge of integrity to patients and professionals alike.

Below is the list of General Electric's cross-country sales offices. Call the one in your locale for complete information on the G-E Regent with new overhead tube hanger. Or write for information to X-Ray Dept., General Electric Company, Milwaukee 1, Wis., Room 1910.

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7, N.Y. - - - - - - 8 Elk St.
A 9, GA. - 1383 Spring St., N.W.
ORE 18, MD. - 3012 Greenmount Ave.
GHAM 5, ALA. - - 707 S. 21st St.
35, MASS. - 1256 Soldier Field Rd.
0 13, N.Y. - - - 960 Busti Ave.
MONT. - - 103 N. Wyoming St.
STON 1, W. VA. - - - - - -
- - 5616 MacCorkle Ave., S.E.
TTE 4, N.C. - 1140 Elizabeth Ave.
NOOGA 3, TENN. - 507 E. Eighth St.
O 7, ILL. - 1061 W. Jackson Blvd.
NATI 25, OHIO - - - - - -
- - - 3056 W. McMicken Ave.
US 12, OHIO - 1373 Grandview Ave.
ND 15, OHIO - 3829 Carnegie Ave.
7, TEX. - - 1616 Oaklawn Ave.
5, COLO. - - 3031 E. 40th Ave.
INES 12, IA. - 2211 W. Grand Ave.
19, MICH. - 18801 W. 7 Mile Rd.
1, MINN. - - 928 E. Second St.
RACUSE, N.Y. - 1937 Teall Ave.
RD 5, CONN. - 528 Farmington Ave.
ULU 1, T.H. - Fort and Queen Sts.
N 1, TEX. - 1830 Westheimer Rd.
APOLIS 7, IND. - 1845 W. 18th St.
NVILLE, FLA. - - 210 W. 8th St.
CITY 6, MO. - 112 W. 19th St.
OCK, ARK. - - 3015 Lewis St.
GELES 29, CAL. - 1225 N. Vermont Ave.
LLE, KY. - - - 501 W. Oak St.
S 3, TENN. - 778 Madison Ave.
FLA. - - - 704 S.W. 27th Ave.
KEE 3, WIS. - - 547 N. 16th St.
POLIS 2, MINN. - 808 Nicolett Ave.

NEWARK 2, N. J. - - - - 11 Hill St.
NEW ORLEANS 25, LA. - 7715 Edinburgh St.
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NORFOLK, VA. - - - 218 Flatiron Bldg.
OKLA. CITY 7, OKLA. - 4030 N.W. Tenth St.
OMAHA 2, NEBR. - - 1617 Dodge St.
PHILADELPHIA 32, PA. - - - - - -
- - - - - Hunting Pk. Ave. at Ridge
PHOENIX, ARIZ. - - 821 W. Adams St.
PITTSBURGH 6, PA. - 231 S. Euclid Ave.
PORTLAND 10, ORE. - 522 N.W. 23rd Ave.
PROVIDENCE 9, R.I. - - 241 Harris Ave.
RICHMOND 21, VA. - 3425 W. Leigh St.
ROANOKE, VA. - 115 Albermarle St., S.E.
ROCHESTER 7, N.Y. - - 75 College Ave.
ST. LOUIS 3, MO. - - - 2010 Olive St.
SALT LAKE CITY, UTAH - 215 S. 4th East
SAN ANTONIO 12, TEX. - - - - - -
- - - - - - - 101 N. McCullough Ave.
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SAN FRANCISCO 3, CAL. - 1269 Howard St.
SEATTLE 9, WASH. - - 217 8th Ave. N.
SHREVEPORT, LA. - - 1511-13 Line Ave.
SPOKANE, WASH. - N. 1112 Washington St.
SPRINGFIELD, ILL. - 917-19 E. Adams St.
SYRACUSE 6, N.Y. - - 3001 James St.
TAMPA 6, FLA. - - - 1009 W. Platt St.
TOLEDO 4, OHIO - - - 520 Broadway
TULSA 19, OKLA. - - 1101 S. Main St.
WASHINGTON 5, D.C. - 806 15th St., N.W.
WORCESTER 5, MASS. - 372 Burncoat St.

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HALIFAX, N.S. - - - 125 Cunard St.
MONTREAL 9, QUE. - - - - - -
- - - - - 8325 Mountain Sights Ave.
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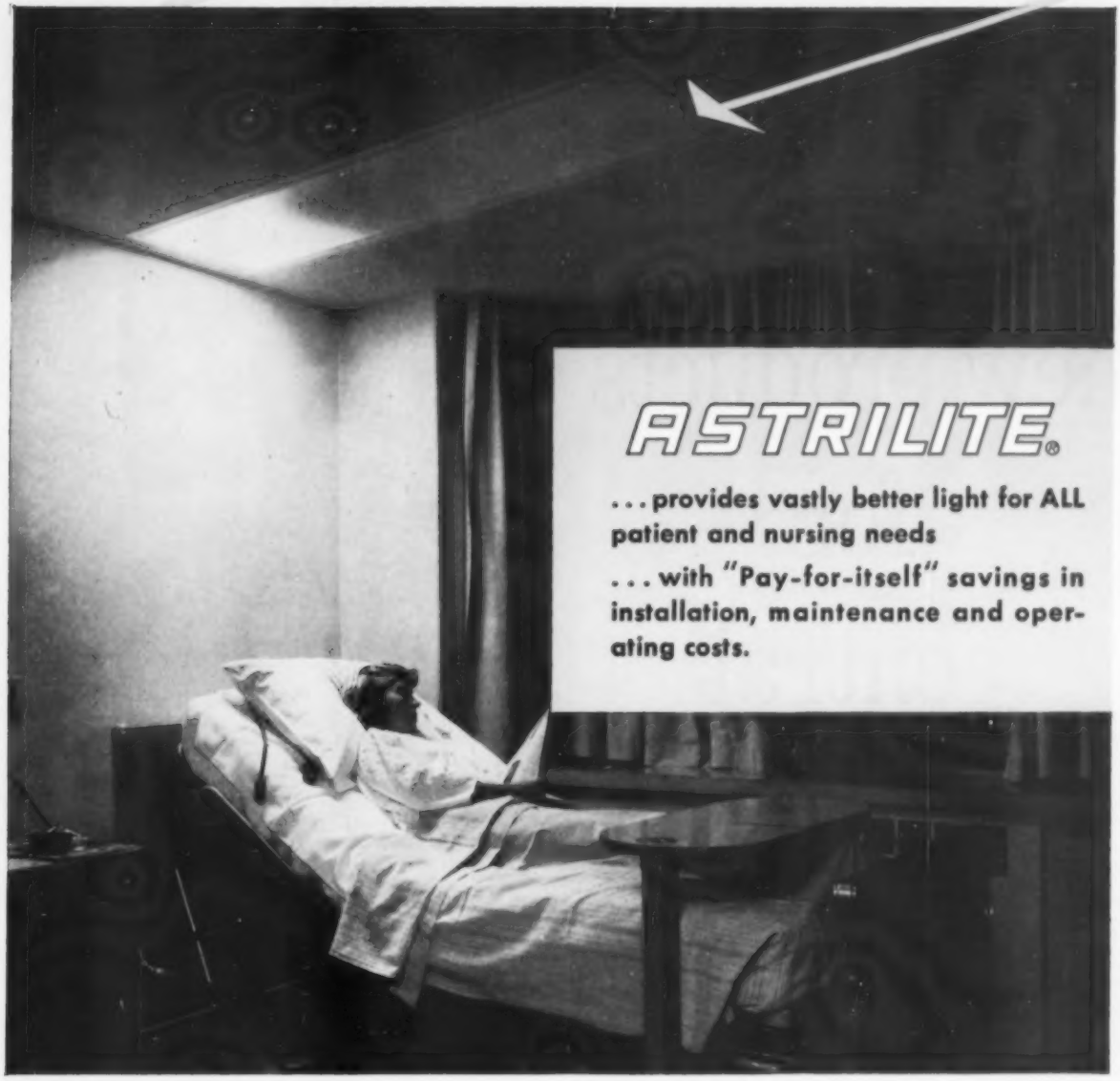
—a "Breakthrough" Concept in Hospital Patient Room Lighting



A single decorative ceiling unit provides (1) soft, flattering, general room illumination; (2) comfortable, visually-correct, non-glare light for reading, makeup, etc.; (3) bed-length light of surgical quality for examination, surgical "prep" and nursing care; and (4) safety night light for nursing convenience and patient comfort.

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This truly revolutionary ceiling unit eliminates the clutter and maintenance of floor, bed, wall and portable lights formerly required in the patient's room.

Even more important, however, ASTRILITE provides diffused fluorescent illumination of comfort and visual qualities vastly superior to harsh incandescents. Because lighting efficiencies per watt are approximately three times greater than incandescents . . . and lamp life as much as ten times longer . . . there are attractive savings in operating and maintenance costs. Designed for flush mounting in new construction or ceiling mounting in existing rooms.

* *Send for illustrated brochure LC-110.*

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The table of tomorrow here today.

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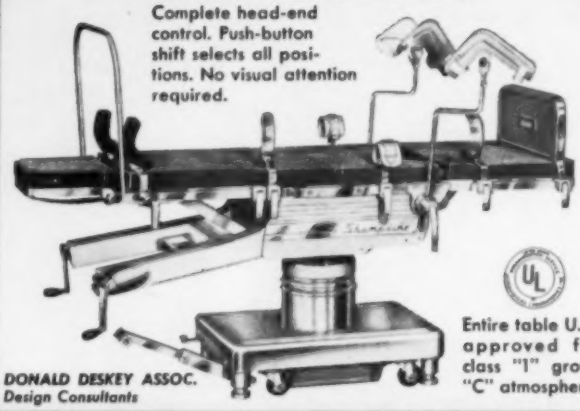

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Entire table U. L. approved for class "I" group "C" atmosphere.

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ADJUSTABLE TABLE FOR ORTHOPEDIC AND NEURO-SURGERY INSTRUMENTS

Rolls over operating table. Places instruments near site for neurosurgery, orthopedic, cranial, facial or neck surgery. Fingertip gear operation adjusts table from 45" to 57" height.

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Cassette inserted from either side, head end, foot end, seat section —for high speed roentgenography during surgery.

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S-1576-A—converts SURG-A-MATIC into ideal table for vein stripping, light cast work and other procedures requiring abduction of lower extremities.

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S-1576-W—quick-acting, snap-on socket controls height and lateral adjustment. Adjustable length accommodates any arm.

S-1576-L—fits in fast-acting side rail clamp . . . fingertip control of radial adjustment.

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28" x 19½" x 34" high. Trays: 24" x 14" x 2¼" deep. Stores OR table accessories when not in use. Removable trays for insertion in Autoclave.

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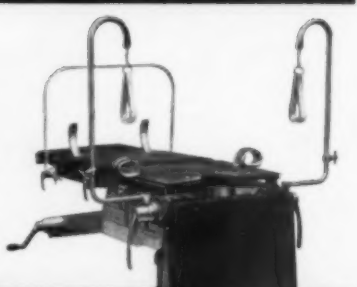
S-1579-J—assures correct positioning and access to patient at all times. Telescoping height adjustment. Quick-acting sockets for adjustment to any position without removing legs from straps.



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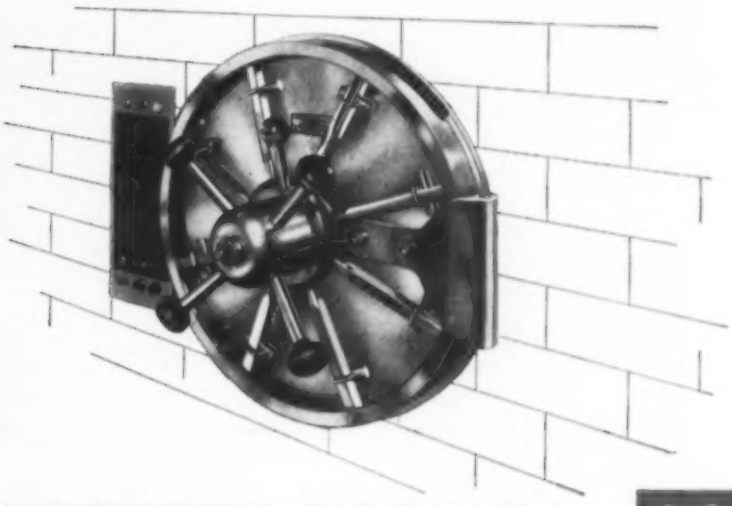

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- Single crank for easy height adjustment

ELECTRIC ADJUSTABLE-HEIGHT

- Raises, lowers, at touch of a switch
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Designed and engineered for superior performance at prices you can afford to pay! These two new Carrom beds can be set up as easily as conventional beds. Indestructible ball-bearing pulleys assure smooth operation, posts are accurately machined for easy and noiseless height-adjustment. Additional quality features include corner posts that accommodate an irrigator rod and fracture frame, and heavy-duty, Trendelenberg-type spring to insure patient comfort. Birch wood end panels add a beautiful, home-like appearance. Choice of colors on end panels. Write for full details today.

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Offers a complete line of matching fine wood furniture

AMERICAN-GRAY
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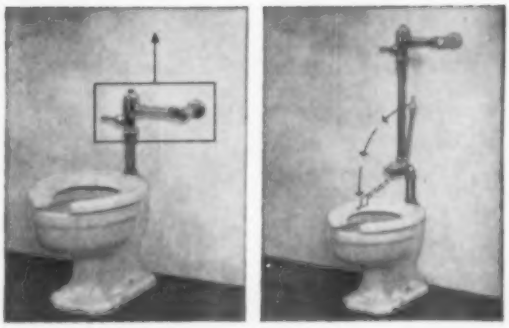
Nursing personnel welcome the ease and convenience of the American-Gray Diverter Valve. Cost-conscious administrators like its simple, low-cost installation, minimum maintenance and time saving features. The Amsco-Gray Diverter Valve eliminates awkward hoses where leaks are both dangerous and annoying. Acceptable under the most rigid plumbing codes, thousands of these improved American-Gray Diverter Valves are saving hours and dollars in hospitals and nursing homes throughout the world.

EASY, ECONOMICAL TO INSTALL

Existing flush valve raised to permit short extensions on either new or existing installations, (left). American-Gray Diverter Valve, placed between flush valve vacuum and toilet . . . easy, economical installation, (right). Top, back and side inlets can be accommodated with complete piping between vacuum breaker and toilet.



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Offices in 14 Principal Cities

COST-CUTTING PROGRAMS FROM HOBART

For more than 60 years every advance in kitchen techniques has been matched by a new Hobart development. This leadership and unsurpassed experience make it possible for Hobart to offer you proven cost-cutting programs designed to improve your food preparation and dishwashing operations.

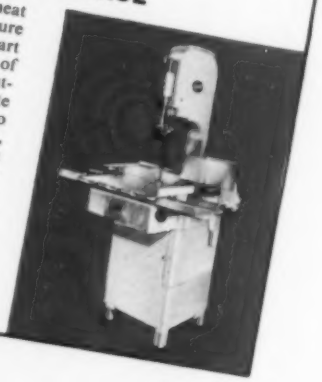
Here are but a few ideas that can improve work patterns...increase productivity...give you menu variety of increased appeal...reduce costs. For each idea there is a specific Hobart machine, matched in size and capacity to your particular needs. And every work-saving Hobart machine is rugged, long lasting, super-productive, easy to clean and keep clean.

For the industry's widest selection of production-planned machines, contact your nearby Hobart Representative. Ask about programs ideally suited to solve a problem of yours. The Hobart Manufacturing Co., Dept. 306, Troy, Ohio.

A

CLOSER PORTION CONTROL

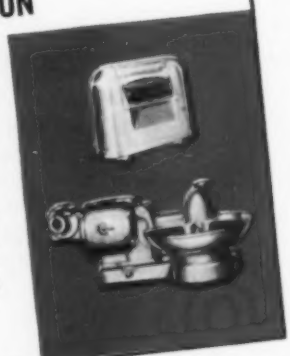
For lower costs, control meat portions more closely...assure faster cutting with a new Hobart Model 5012 power saw. Size of cut is accurately set for full cutting clearance. Rigid gauge plate assures straighter cutting—no wedge-shaped cuts. Compact, this saw can be installed flush with wall—no setting or cleaning operations at rear of saw. Exclusive Hobart design permits quick removal of parts without tools for thorough, easy cleaning—faster than any other saw. Other models available.



B

NEW TASTE SENSATION

Here's a new menu item with high customer appeal and low material cost. It's a tender-taste steak made by the team of Hobart food cutter and tenderizer machines. Using trimmings and low-cost cuts such as neck, shank, etc., the food cutter blends-in the flavor and fat of "penny-a-pound" suet while removing tough tendons and gristle. Tenderizer then knits a well-formed, tenderized steak. Ask for a demonstration of this versatile team in your kitchen.



C

CONTROLLED PASTRY RECIPES

Heavy bread doughs...lighter doughs for specialties such as French pastries—your Hobart mixer with *positive* drive and *positive* speed selection will mix batch after batch to exact recipe requirements. Ideal, too, for all other mixing! Exclusive Hobart planetary mixing action thoroughly blends all ingredients. Hobart motors, positive drive, and exact speed selection eliminate speed fluctuation due to variations of batch consistency or drive slippage. Full attachment line for kitchen-wide utility.

D

BETTER DISHWASHING

The speed and capacity of Hobart dishwashing, glass-washing and scrapping equipment can bring economy and efficiency to your entire kitchen layout. Flight-type units as illustrated are fast loading for completely automatic fresh-water scrapping, power washing, power rinsing and final rinsing. The Hobart line offers you over 50 dishwasher models including semi-automatics, rack-conveyor and flight-type automatics—counter-top or undercounter models—and the industry's most complete line of scrappers.

E

PORTION-CONTROLLED SLICING

Cleaner, faster, portion-controlled slicing of cheese, luncheon meats, ham and corned beef is assured with all Hobart slicers. The reason for this unsurpassed performance is the *solid stainless, stay-sharp* blade. Every blade is made by an exclusive Hobart process that controls quality from casting of molten metal to finished blade. Long-wearing with razor-sharp edge, it will *never* stain, pit or blacken like ordinary blades. Free of dirt and juice-trapping crevices, your Hobart slicer is easily and quickly cleaned—without use of tools.

F

NEW COLD-WATER GLASS WASHING

Using only water from your cold-water tap and a low-cost detergent-sanitizer, the Hobart *Sani Quik Glassmaster, with its exclusive features,* turns out a sanitized, crystal-glow clean glass in just four seconds at automatically timed operation. Test-proven 50 times more effective than dip-and-rinse tub method, Sani Quik is uniquely compact for all types of installations. Handles all popular sizes and types of glasses. Approved for listing by National Sanitation Foundation and Underwriters' Laboratories. Self-sanitizing, self-cleaning, and automatic.

G

PEEL POTATOES...AND COSTS

Peeling that now takes hours in your kitchen by hand methods can be done in a matter of minutes with Hobart peelers (various capacities)—resulting in substantial savings in costs as well as root vegetables. Heart of Hobart design is the exclusive cast-iron abrasive disc that has silicon carbide fused into the iron—next to diamonds in hardness. Combined with special ribbed interior hopper, disc delivers finest peeling known—no bruising, no "flats," uniform output...easily cleaned.

The Most Complete Line with Nationwide Sales and Service

Hobart MACHINES

The World's Oldest and Largest Manufacturer of Food, Bakery, Kitchen and Dishwashing Machines

Send Coupon Now!

The Hobart Manufacturing Company
Dept. 306, Troy, Ohio

Please send more information on cost-cutting programs:

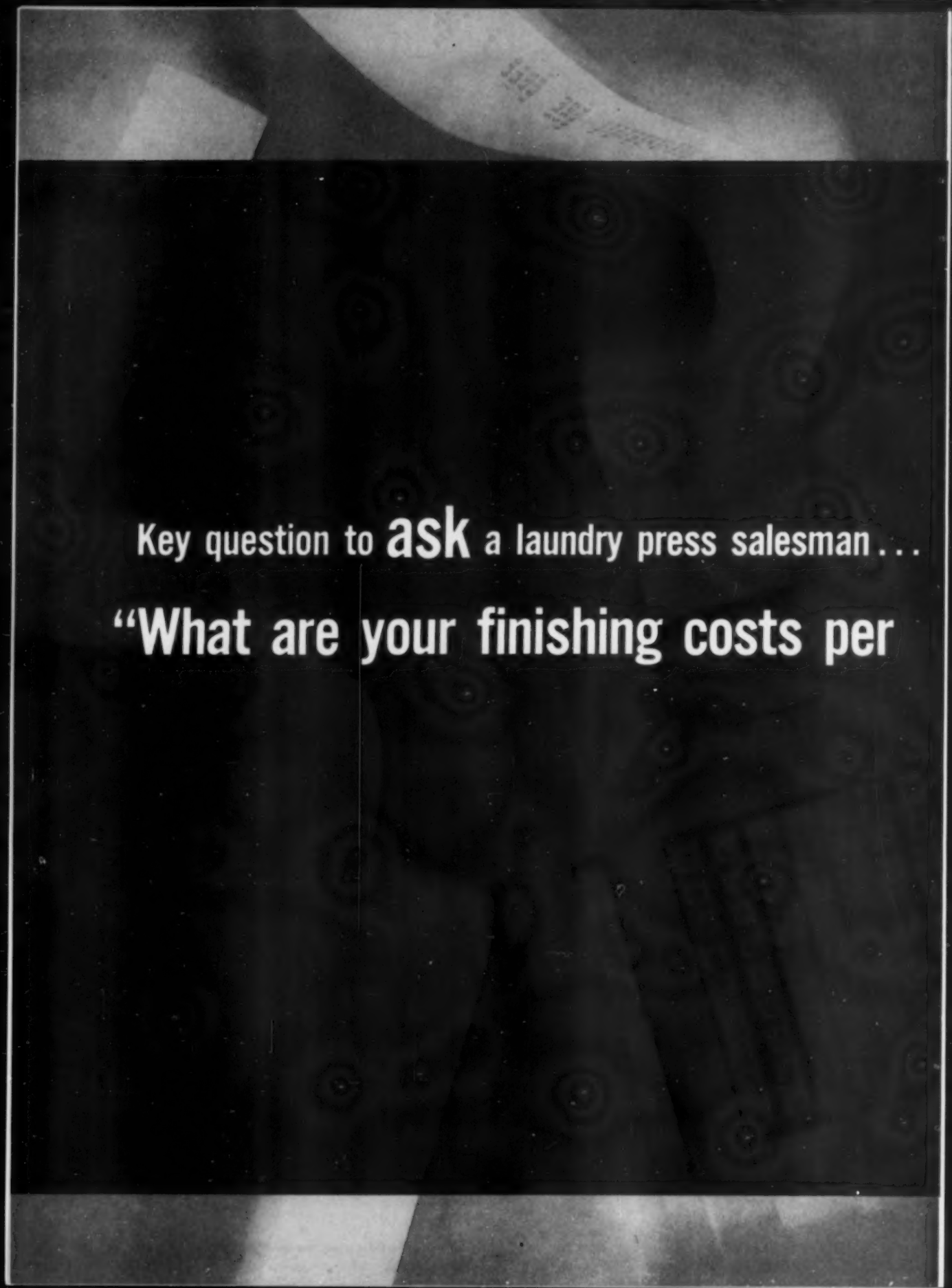
A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐

Name.....

Location.....

Address.....

City.....Zone.....State.....


Key question to ask a laundry press salesman . . .
"What are your finishing costs per

hundred?"

At Flushing (N. Y.) Hospital and Dispensary these two units of Model 54½ Super-Zarmo and Model 106-A Super-Zarmoette Presses finish uniforms and other garments at the lowest possible cost per hundred pieces.

Your American salesman's answer is positive and direct. "Comparison tests prove our Model 54½ Super-Zarmo Apparel Press will save you an average of *90c or more per 100* on your apparel finishing costs!" And, he'll back up his answer with facts! This applies to every hospital laundry that finishes garments of any type. Here's why:

• Extra-large buck requires fewer press lays. • Unique shape of buck gives unlimited versatility. Accommodates a wide variety of garments, eliminating extra lays on other presses. • Powerful, unvarying *direct-upward pressure* quickly imparts a fine-quality finish to even the heaviest garments.

No other laundry press can match the Model 54½ Super-Zarmo for quality, speed and versatility.

For a sure way to lower *your* cost per hundred garments, call your nearby American representative. He'll gladly show you a Model 54½ Super-Zarmo Press Unit in action. Or, if you prefer, mail the coupon for complete information.

The American Laundry Machinery Company, Cincinnati 12, Ohio

You get more from

American

The American Laundry Machinery Company ALM-606
Cincinnati 12, Ohio

Please send Catalog AK 530-542 (54½) which tells how the Model 54½ Super-Zarmo Press will lower my finishing costs.

Name_____

Care of_____

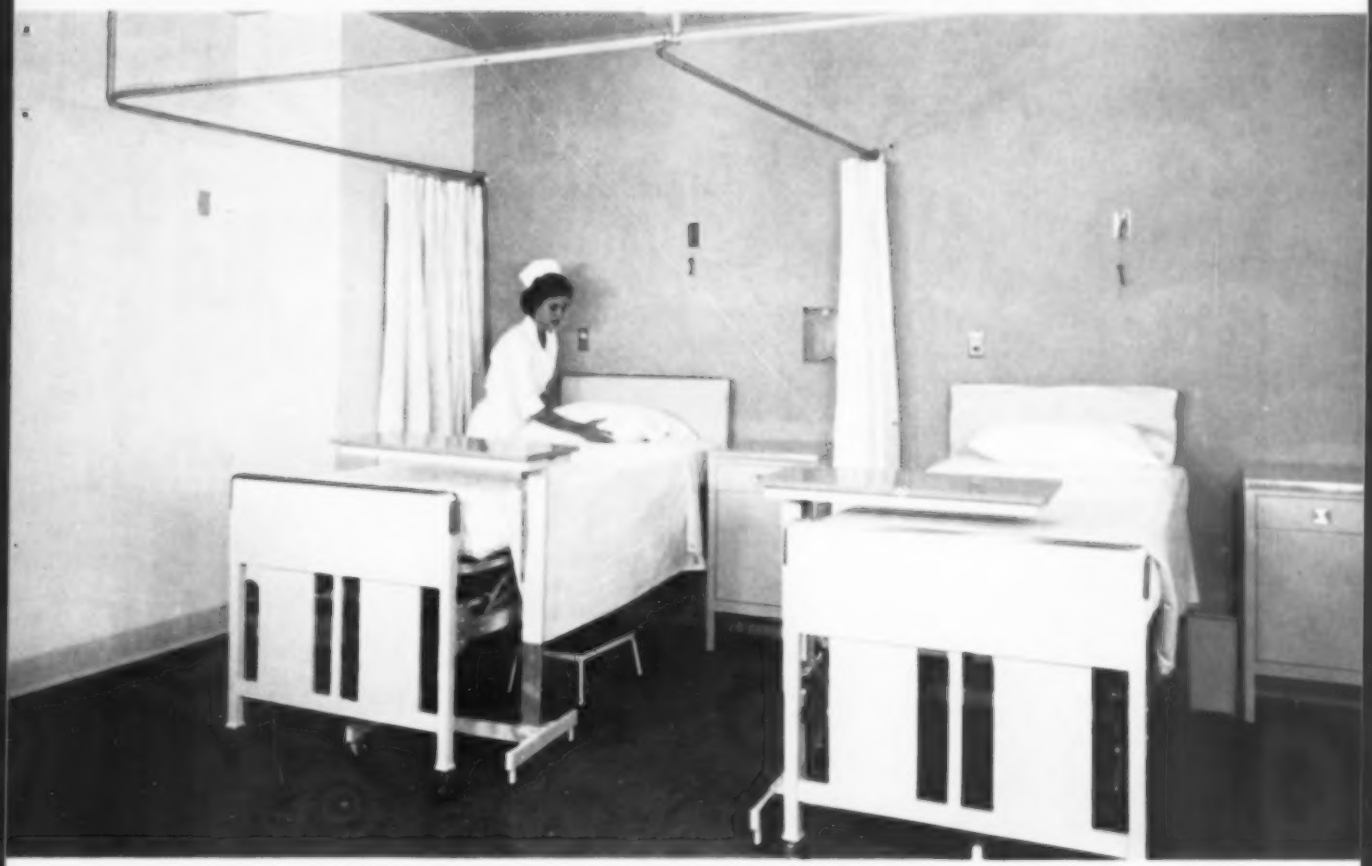
Address_____

City_____ Zone____ State____

In Canada—The Canadian Laundry Machinery Company, Ltd., 47-93 Sterling Road, Toronto 3, Ontario

Pittsburgh COLOR DYNAMICS®

gives a whole new world of helpful color to Atlanta's beautiful new Grady Memorial Hospital



Modern painting system adds to comfort of patients and efficiency of medical and nursing staffs

Recognizing the increasing importance of the therapeutic value of color, authorities of the $26,000,000 Grady Memorial Hospital, of Atlanta, Ga., have given this vast institution a whole new world of helpful color.

• **By using Pittsburgh's** system of COLOR DYNAMICS, patients have been given an environment that soothes, relaxes and encourages. Efficiency of medical and nursing staffs has been improved.

• **More than fifty** different colors were used to counteract the austere impersonality so often associated with large hospitals. Patients' rooms were color-styled to enhance morale and speed recovery. Colors were carefully chosen to relieve eyestrain in operating rooms, tension in examining rooms and claustrophobia in labor rooms. Cheerful hues for nurses' stations aid alertness. Restful colors make living quarters of resident staffs more attractive and comfortable. Reception and waiting rooms were painted in tones designed to give confidence and encouragement to visitors.

• **You, too, can make** your hospital more attractive and efficient with COLOR DYNAMICS. And you can achieve these benefits at no greater cost than required for normal maintenance painting.

We'll make a functional color study of your hospital—FREE

● To help you color-plan your hospital correctly, we'll be glad to send you a free copy of our book explaining COLOR DYNAMICS and how to use this painting system most effectively. Better still, we'll make a detailed color study of your hospital, or any part of it, with complete specifications, without cost or obligation. Call your nearest Pittsburgh Plate Glass Company branch and arrange to have one of our representatives see you at your convenience. Or mail coupon below.

Pittsburgh Plate Glass Co.,
Paint Div., Dept. MH-69
Pittsburgh 22, Pa.

☐ Please send me a FREE copy of **"Color Dynamics."**

☐ Please have your representative call for a Color Dynamics Survey of our properties without obligation on our part.

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PAINTS • GLASS • CHEMICALS • BRUSHES • PLASTICS • FIBER GLASS

PITTSBURGH PLATE GLASS COMPANY

IN CANADA: CANADIAN PITTSBURGH INDUSTRIES LIMITED

New for You – in obstetrical work

POLAR WARE *Improved* Placenta Basin

of stainless steel

Modern obstetrical techniques and asepsis practice in the delivery room have created a demand for a better method of placental examination than on the instrument table.

So it is that Polar Ware offers the obstetrician, in this new placenta basin, an improved means of inspection. The perforated tray — which has finger holes for easy removal — provides for drainage and collection of blood, clots and amniotic fluid. The placenta, then, can be more readily and completely observed, thus reducing the need for manual exploration of the uterus to those cases where abnormal conditions are suspected.

Made entirely of heavy gauge stainless steel for long service and basic economy, this Polar basin is drawn seamlessly to avoid any weld lines or cracks that might harbor bacteria. Its sterility can be assured. And because it is Polar Ware you know that while it represents the finest in metal craftsmanship it is not expensive.

Ask the supply men who call. You'll find the best houses carry it . . . an exclusive Polar Ware first.

Polar Ware Co. *4300 LAKE SHORE ROAD SHEBOYGAN, WISCONSIN

Merchandise Mart — Chicago 54 Room 1455 · *800 Santa Fe Ave. Los Angeles, Calif. · *415 Lexington Avenue New York 17, N. Y. · Offices in Other Principal Cities *Designates office and warehouse

Hollister *Ident-A-Band*®, the *original*, the *positive* all-patient, on-patient identification

It's sure because it's *sealed*. It's the Ident-A-Band—the original—and still the only protection that is really positive. Ident-A-Band's method of achieving a permanent seal is so easy and quick there is no need to settle for less. That's why Ident-A-Band is ideal for the all-patient, on-patient identification now recommended by the American Hospital Association.

Ident-A-Band is skin-soft and custom-fitted—it's so comfortable a patient quickly forgets that he is wearing it. Nurses like it, too, because its positive identification saves their time, avoids errors. The Ident-A-Band system has been proved and improved on millions of patients over a period of eight years. In addition to its original positive seal, Ident-A-Band now offers two new finger-pressure seals, thus meeting every need of every department. Write for samples, prices and information.

Hollister®

Hollister Incorporated, 833 North Orleans Street, Chicago 10, Illinois
Sold in Canada by Hollister Limited, 160 Bay Street, Toronto 1, Ontario

MAKE REMINDERS CLEAR NEAT AND NOTICEABLE WITH HOLLISTER BED SIGNS

Reminders in writing are difficult for personnel to read, easy to overlook, and anything but professional in appearance. That's why the trend is to Beautiful Bed and Room Signs by Hollister. You can read them across the room and they save time too.

You "write" the message by simply taking a colorful, plastic-coated card from a rack in the nursing stations. You "attach" it to the bed by simply sliding the card into the clear Plexiglas® sign. Patients and visitors are impressed by the beautiful, efficient appearance of these bed signs . . . and the staff takes pride in the professional look that they add.

A complete system of Hollister Bed and Room Signs helps you maintain the neatness that patients and visitors expect to see in a hospital. And it is one more way in which progressive hospitals save time for a busy nursing staff. These are just the highlights. Details will be sent to you in the 16-page booklet, "Beautiful Bed Signs." Write for your free copy.

Hollister®
INCORPORATED

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Radiant Ceiling News

With Burgess-Manning Ceilings — Your Building Is Better — Your Building Budget No Bigger

Burgess-Manning Radiant Acoustical Ceiling Especially Advantageous for Psychiatric Hospitals

The Burgess-Manning Radiant Ceiling has many features that make it especially desirable for all hospital buildings designed for psychiatric use.

With the Burgess-Manning Radiant Acoustical Ceiling there are no hot radiators or registers within reach that can harm, or be harmed by an irresponsible person. The panels that transmit radiant energy for heating or cooling the space are located in the ceiling. Thermostatic controls can also be located out of reach. With the Burgess-Manning Radiant Ceiling as the heat source, floors are always comfortably warm, and there is no appreciable variation in temperature from floor to ceiling, or in any part of the room.

Acoustically this ceiling absorbs noise and provides maximum quiet for patients and staff.

The absence of drafts caused by convection currents, largely unavoidable with other heating systems, is another feature that is especially desirable in hospital installations.

These considerations prompted the selection of the Burgess-Manning Radiant Acoustical Ceiling for the Marquardt Building almost as much as its other features—superior comfort conditioning, economy of operation, low cost maintenance, and the virtually instantaneous response to thermostatic control.

Marquardt Building, Augusta State Hospital, Augusta, Maine.

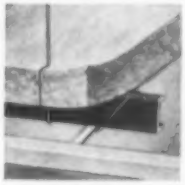
Radiant Acoustical Ceiling Structurally Simple

Considering the triple function—heating, cooling and noise control—performed by the Burgess-Manning Radiant Acoustical Ceiling, its construction is amazingly simple and compact. It consists of only 4 major parts.

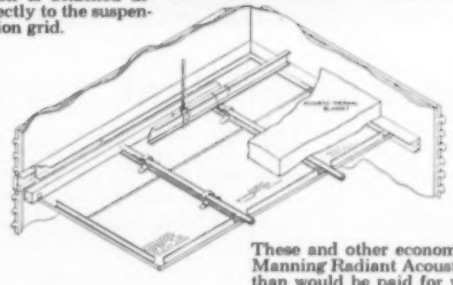
1. Suspension
The standard suspension system of 1½" channels on 4 ft. centers is ordinarily used.

2. Water Circulating Coil
The grid type coil is made from pre-fabricated headers to which ½" laterals are welded. A sinuous type coil can be used where conditions make it desirable. Either type coil is attached directly to the suspension grid.

3. Acoustic Blanket
The non-combustible sound-absorbing blanket, with the required noise reduction coefficient, is laid on top of the suspension grid.



4. Snap-on Panels
Heavy gauge perforated aluminum panels of the proper thermal conductivity are attached directly to the water circulating coil.



This isometric drawing shows all 4 parts assembled—a relatively simple construction that replaces the conventional radiators, or hot air ducts used for convectional type heating, and that permits reduction in size of ventilating air handling equipment such as blowers, fans, coils, filters, etc.

These and other economies permit installation of Burgess-Manning Radiant Acoustical Ceiling at a cost equal or lower than would be paid for various combinations of convection heating and air cooling, plus a suspended acoustical ceiling.

Write for descriptive Burgess-Manning Catalog No. 138-2M

Heating Cooling Acoustical

BURGESS-MANNING COMPANY

Architectural Products Division

5970 Northwest Highway, Chicago 31, Ill.

SEE OUR CATALOG IN SWEET'S ARCHITECTURAL FILE OR WRITE FOR COPY

variety of skills, it's best left to specialists"

J. B. HAMIL
Chief Engineer

"Here at the GRADY MEMORIAL HOSPITAL we have a House Staff of 150 doctors and a Visiting Staff of 500 leading Atlanta physicians to properly and adequately minister to eligible patients from a community of 1,000,000. Ours is the *specialist's approach*," says J. B. HAMIL, Chief Engineer.

"We take the same approach to our vitally important vertical transportation system. We have 13 OTIS Passenger Elevators, 6 OTIS Service Elevators and 19 OTIS Dumbwaiters. They vary in design, equipment and maintenance requirements according to their specific duties. A careful study of the OTIS *specialist's approach* to their maintenance convinced us that only OTIS can keep our vertical transportation running like new. We had only to look back on long years of highly satisfactory OTIS Maintenance in the original GRADY MEMORIAL HOSPITAL to confirm our judgment."

What is the OTIS *specialist's approach* to elevator maintenance? It is MEN . . . MATERIALS . . . METHODS.

MEN: Elevator maintenance is no one-man job. It is an organization task requiring experts in many lines. No individual, even if he devoted his entire time to the job, could do it properly. It calls for men with an unusual combination of skills plus long OTIS training in studying parts, assemblies, functions, replacement procedures, testing and adjusting.

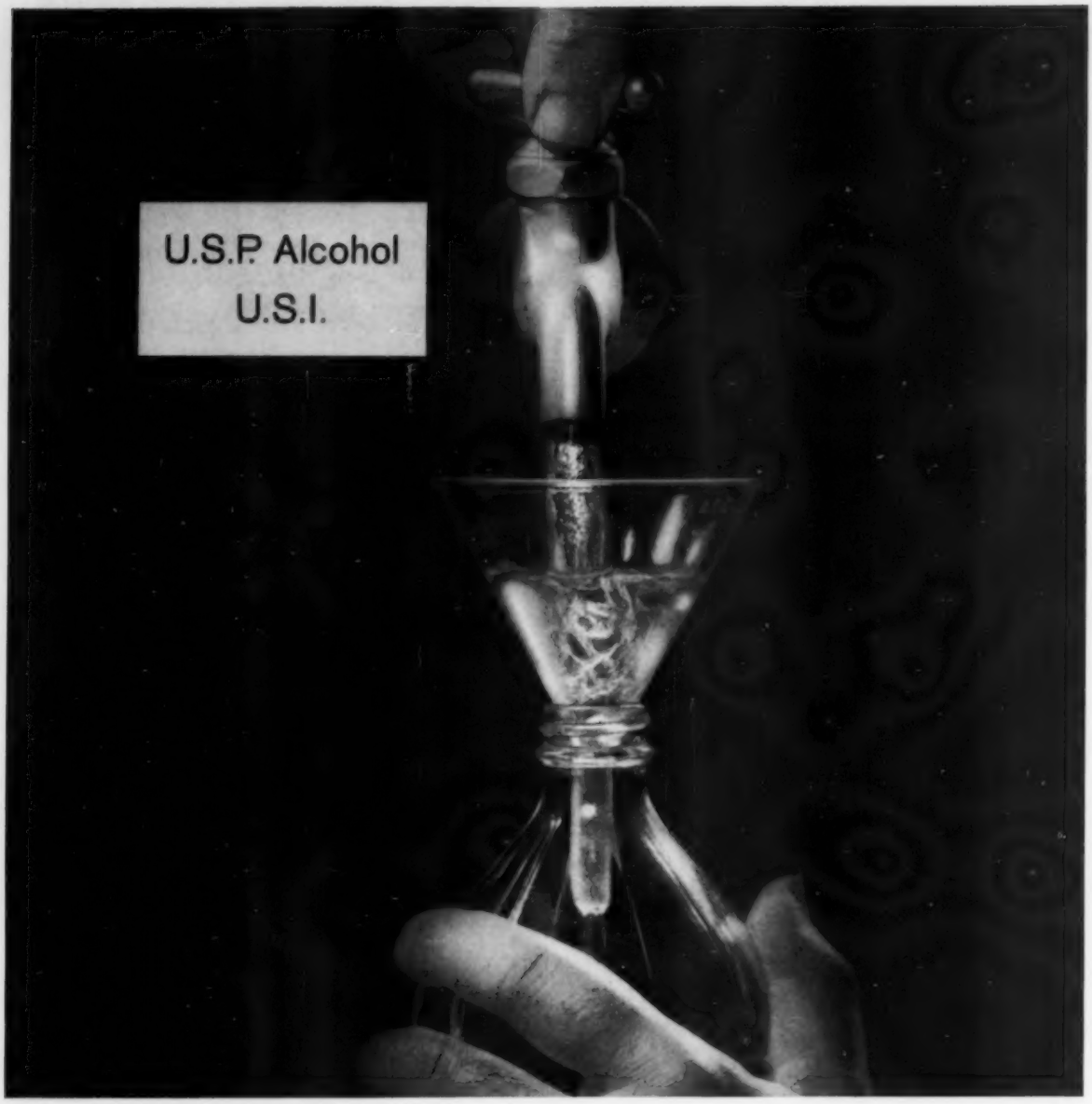
MATERIALS: Original OTIS parts and specially designed OTIS maintenance equipment are within one hour of 90% of all OTIS elevators in the U.S. for use in scheduled replacements—and to hold emergency shutdowns to a minimum.

METHODS: With more than 40,000 elevators under OTIS maintenance, OTIS has developed an actuarial procedure that replaces wearing parts well in advance of their breakdown point to hold shutdowns to an absolute minimum and assure the highest possible safety.

elevator maintenance

THAT KEEPS ELEVATORS RUNNING LIKE NEW

OFFICES IN 297 CITIES ACROSS THE UNITED STATES AND CANADA



It's like having alcohol piped in ...when you buy from U.S.I.

Piping alcohol into hospital pharmacies is not practical. It's not necessary either. U.S.I.'s dependable delivery service keeps one of nine nation-wide bonded warehouses on tap for your hospital . . . assures ready availability of the pure alcohol you require.

Being able to count on U.S.I. alcohol deliveries helps you avoid stocking more than you need. Storage space is freed and inventory problems are reduced.

There are other advantages as well when you buy U.S.I. alcohol. U.S.I. salesmen can help you with any questions involving the use of alcohol – for example, the handling of alcohol permits and records.

U.S.I. is America's oldest producer of hospital and industrial alcohol. For over half a century, we have supplied pure alcohol to hospitals throughout the country. When you buy from U.S.I., you get the benefit of this long experience – and you get service that's as modern and dependable as a pipeline.

U.S.I. pure alcohol U.S.P.

U.S.I. INDUSTRIAL CHEMICALS CO.
Division of National Distillers and Chemical Corp.
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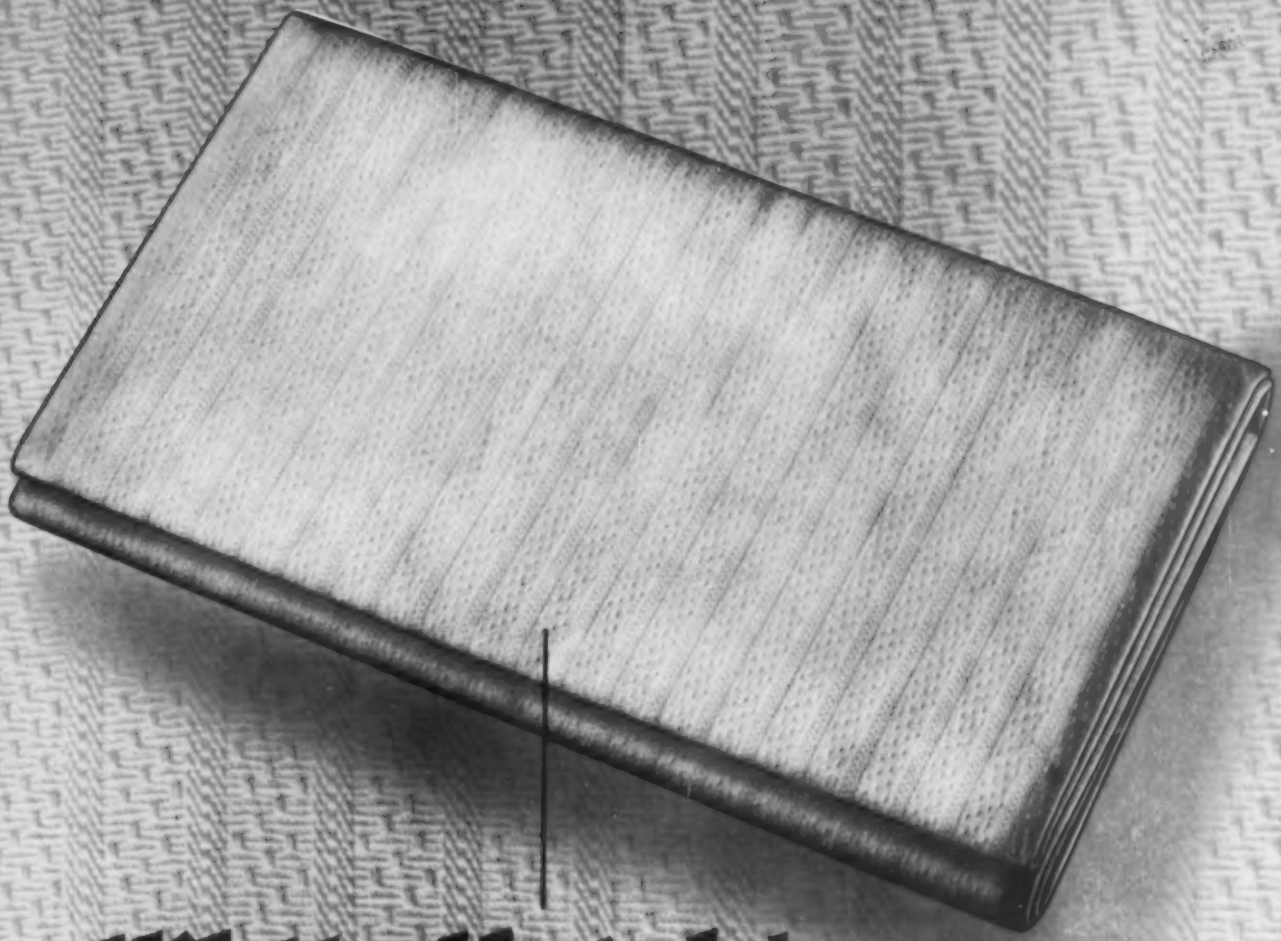

White Knight

White Knight
WILL ROSS, INC. MILWAUKEE, WIS.
TRADE MARK

Piqué Bedspreads

. . . the most practical hospital spread for

appearance, economy, service

MANUFACTURERS AND DISTRIBUTORS OF HOSPITAL AND SANATORIUM EQUIPMENT AND SUPPLIES

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COLGATE BEAUTY WHITE

MEETS RIGID HOSPITAL REQUIREMENTS
BECAUSE IT IS "TAILOR-MADE"
FOR HOSPITAL USE.

HARD MILLED FOR UTMOST ECONOMY,
THIS MILDLY FRAGRANT BATH SOAP GIVES
ABUNDANT LATHER IN ALL TYPES OF WATER.

NEXT TIME, SPECIFY BEAUTY WHITE.
YOUR PATIENTS WILL APPRECIATE IT
—AND YOU'LL SAVE MONEY!

COLGATE-PALMOLIVE COMPANY, 300 PARK AVENUE, NEW YORK 22, N.Y.
ATLANTA 5, GA. • CHICAGO 11, ILL. • KANSAS CITY 11, MO. • OAKLAND 12, CALIF.

B.F.Goodrich

Here's how hospitals cut maintenance costs with Koroseal fabrics

B.F.Goodrich Koroseal fabric-backed vinyl wall coverings eliminate the need for periodic painting. Koroseal cleans easily with soap and water, keeps its sparkling good looks for years with practically no maintenance costs. Koroseal upholstery—in coordinated colors and patterns—also takes severe usage with little or no signs of wear.

Koroseal wall coverings meet the fire resistance requirements of Fed. Spec. CCC-A-700. For free swatches, write Dept. MH-6, *B. F. Goodrich Industrial Products Company, Marietta, Ohio.*

Beautiful, durable Koroseal protects the walls of this medical clinic in Dallas, Texas.

Koroseal's Ambassador pattern, in attractive sage green, adds long-lasting beauty to the Osteopathic Hospital in Grand Rapids.

Colorful, inviting Koroseal armors these lounge chairs in the main lobby of the hospital at University of Michigan, Ann Arbor.

New Everest pattern...excellent for corridor and room wainscoting. Heavy weight for extra abrasion resistance.

Koroseal®

wall covering and upholstery

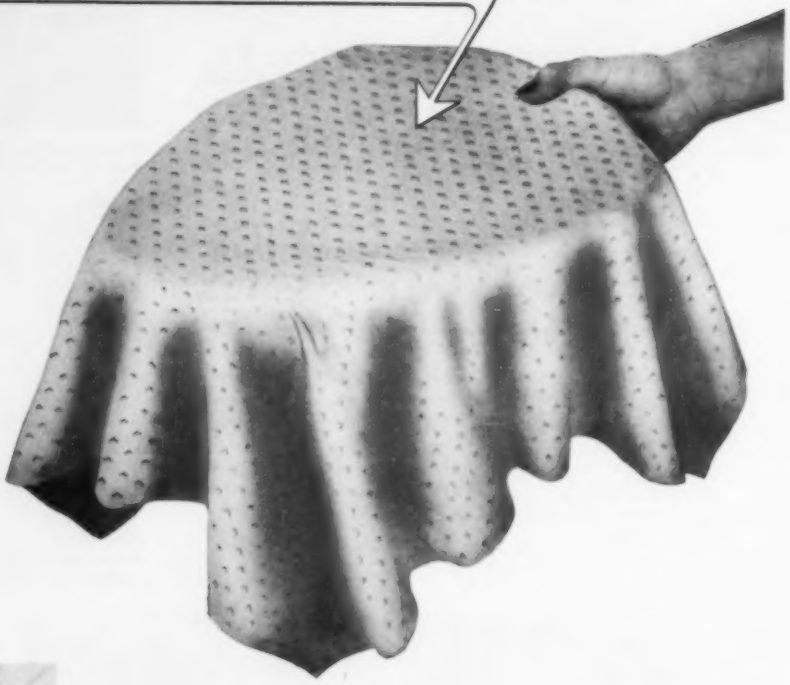
B.F.Goodrich ***Koroseal supported vinyl fabrics***

for hospital protection against cross infection

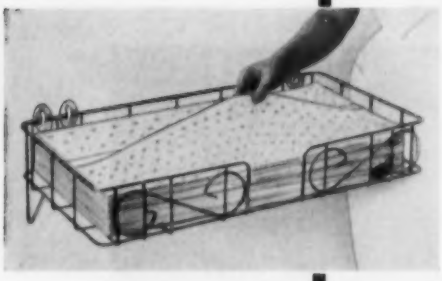
the IPCO PAN-DRAPE

DISPOSABLE, FLUSHABLE BED PAN COVER

another IPCO first!



Requires no new techniques.
• • •
Drapes pan completely.
• • •
Flushes instantly.
• • •
Makes an essential nursing task more agreeable.
• • •
Eliminates costly cloth covers.
• • •
Eases laundry burden.
• • •
Costs less than one cent each.



Pan-Drape Container designed to hold a generous supply of the IPCO Pan-Drape bedpan covers. Container sets on shelf or can be easily mounted on tile wall.

Inquire About Our Free Offer of These Containers

A specially embossed cellulose material that drapes and clings to pan like cloth

Key hospitals everywhere are enthusiastic in their praise of the IPCO Pan-Drape . . . today's most welcome aid in the fight against cross infection. Here is the ideal replacement for makeshift yet costly cover cloths that require constant laundering — and carry with them the possibility of cross infection. The IPCO Pan-Drape handles easily, quietly, quickly — its high degree of absorbency assures safe, instant flushability within the bedpan washer-sterilizer.

A BOX OF 250 FREE SAMPLES AVAILABLE UPON REQUEST

a complete source for hospital supplies and equipment

IPCO HOSPITAL SUPPLY CORP.

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OTHER OFFICES: CHICAGO 45, ILL., DALLAS 35, TEXAS

Clinical findings in 900 patients show the selective antihypertensive action of Singoserp

IN 736 PATIENTS, BLOOD PRESSURE FELL AN AVERAGE OF 30.7 mm. Hg:

- more than half of these patients suffered from **moderate to severe hypertension**
- more than half of the cases involved hypertension of at least 6 years' standing, with **many histories of up to 20 years' duration**

THE SIDE-EFFECTS PROBLEM WAS MINIMIZED IN MOST PATIENTS:

Chart shows gratifyingly low incidence of side effects in 233 patients given Singoserp with no other antihypertensive medication

Side Effect	Number	Per Cent
Lethargy	7	2.9
Headache	6	2.5
Gastrointestinal upset	3	1.2
Vertigo	2	0.8
Nasal congestion	1	0.4

DOSAGE: Initially, 1 to 2 tablets (1 to 2 mg.) daily.
SUPPLIED: Singoserp *Tablets*, 1 mg. (white, scored); bottles of 100.
Samples available on request. Write to CIBA, Box 277, Summit, N.J.

Singoserp®
(syrosingopine CIBA)

remember
Serpasil®
(reserpine CIBA)
for the anxious hypertensive with or without tachycardia

a major improvement in rauwolfia

a major advance in antihypertensive therapy

CIBA
SUMMIT, N.J.

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Stop
this
with
this!

Honeywell Pneumatic Round, world's most popular thermostat.

Nurses aren't trained to control room temperatures Honeywell bedside thermostats are.

Honeywell bedside thermostats free busy nurses from chambermaid chores.

Today, when 64% of hospital expenditures are for payroll, one important answer to cost reduction lies in increasing self-service by the patient. And Honeywell Bedside Temperature Control allows patients to adjust room temperatures to suit themselves, frees nurses from opening and closing windows, filling hot water bottles, carrying blankets and adjusting heating and cooling equipment.

In addition, Honeywell Bedside Temperature Control helps speed patients' recovery because it provides individually-controlled comfort and in special cases, doctors can prescribe room temperatures ideal for each patient.

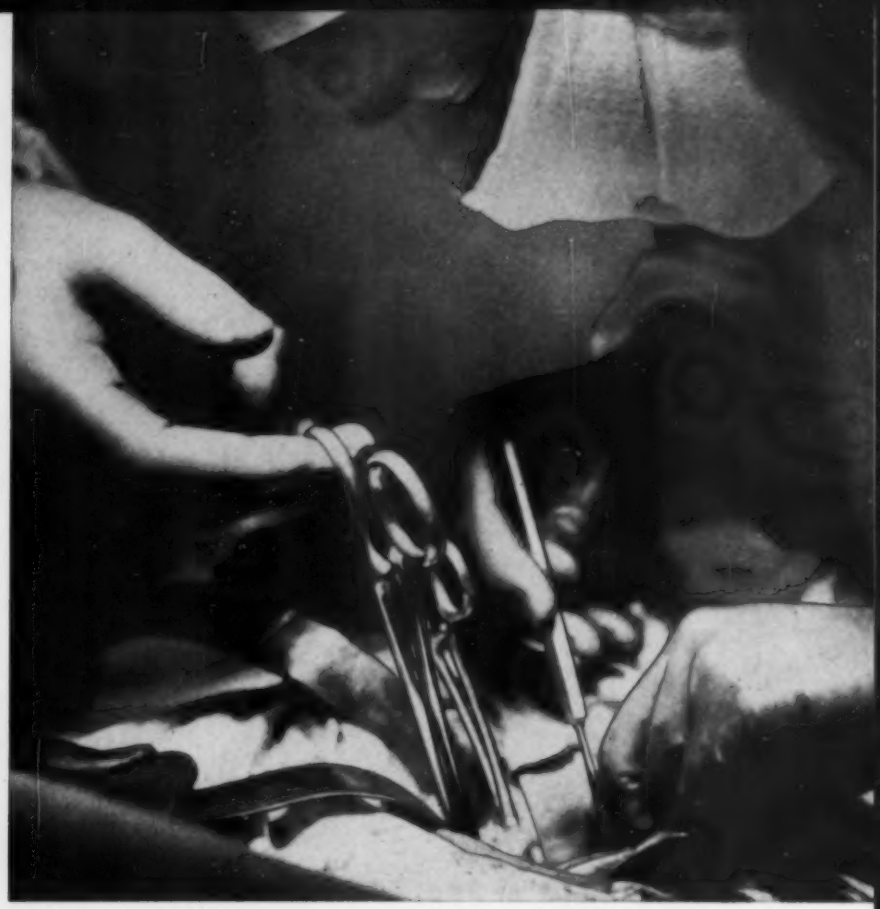
Specify Honeywell Pneumatic Bedside Temperature Control for your new hospital or addition. Honeywell Electric Bedside Temperature controls can be added to existing rooms without redecorating or tearing out walls. The outer ring of the famous Honeywell Round Thermostat snaps off for easy decorating, too.

For more information, call your local Honeywell office or write Minneapolis-Honeywell Regulator Co., Department MH-6-07, Minneapolis 8, Minnesota.

Honeywell

H First in Control

don't let *any* hospital hands spread disease



USE

GERMA-MEDICA®

LIQUID SOAP WITH HEXACHLOROPHENE

Hands do the work in every hospital . . . and hands can carry disease. That's why *all* hospital hands . . . from chief surgeon to typist . . . should be clean and disease-free. Now Germa-Medica Liquid Surgical Soap with Hexachlorophene makes this standard of cleanliness possible throughout the hospital.

Tests by an independent research laboratory prove a daily 3-minute wash using Germa-Medica*, diluted as much as 4:1, reduces bacteria in the area cleansed well below safe levels, produces a bacteriostatic condition that lasts for many hours. Yet highly-concentrated Germa-Medica *costs only 1/5c a wash.* A fine soap made with imported olive oil and an effective emollient, Germa-Medica* with Hexachlorophene does not leave hands irritated or sensitized.

Help control the spread of communicable disease by using Germa-Medica for hand washing everywhere in your hospital. Write today for a free sample. Test the remarkable germicidal action of Germa-Medica Liquid Soap with hexachlorophene.

MAIL COUPON TODAY!

HUNTINGTON LABORATORIES, INC.
Huntington, Indiana

☐ Please send free sample of Germa-Medica with Hexachlorophene and test result booklet.

☐ Have your representative call.

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HUNTINGTON, INDIANA
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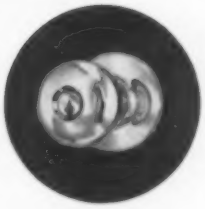
Fresno Community Hospital Addition—

QUALITY IN EVERY DETAIL

SCHLAGE LOCKS THROUGHOUT



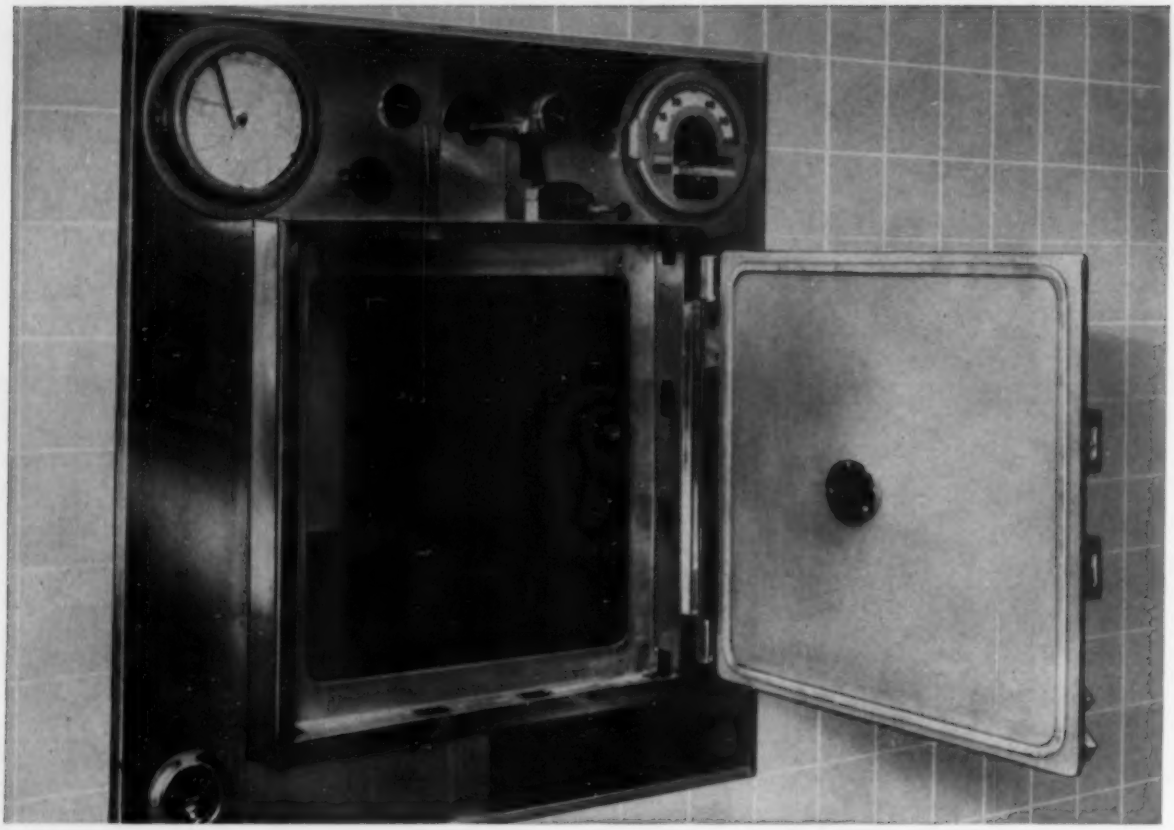
KNOB DESIGN: Plymouth
CHASSIS: Heavy-duty stainless steel

PAINSTAKING attention to the requirements of the staff and the well-being of the patients has made the 200-bed addition to the Fresno Community Hospital a showplace in its field.

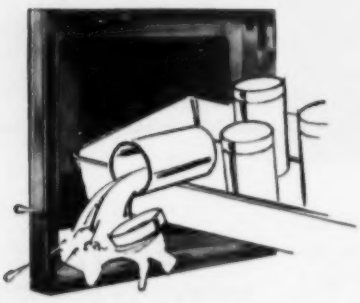
Such refinements as wall-to-wall carpeting in public rooms and corridors; television, radio and telephone for each room; oxygen piping into each room and individual air-conditioning control for each room add to the efficiency and comfort of this modern hospital. The natural lock choice was Schlage, with its corrosion-resistant, stainless-steel trim so necessary to resist the strong cleaning solutions used in hospitals.

Schlage has a complete line of locks with features specifically designed for hospitals. For your new building, addition or remodeling, specify Schlage. There is no finer name on a latch plate. Schlage Lock Company ... San Francisco ... New York ... Vancouver, B.C.

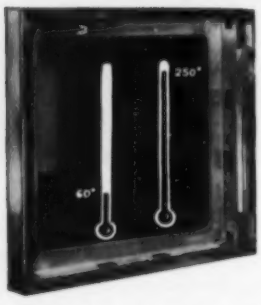
AMERICA'S MOST DISTINGUISHED LOCK BRAND



How new Monel end ring improves sterilizer performance



Resists Corrosion — Fusion welding of a Monel End Ring to the Nickel-clad steel chamber on new Wilmot Castle CR bulk sterilizer now armors the entire unit against corrosive attack of spilled saline solutions and organic debris. Prevents leaks, reduces maintenance.



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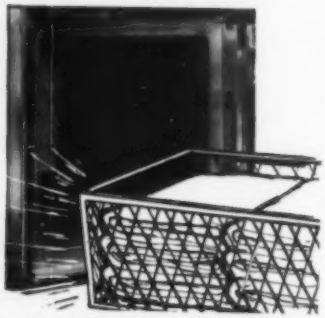

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SMALL HOSPITAL QUESTIONS

Keeping the O.R. Clean

Question: We are currently examining our aseptic routines in the operating room area with a view toward eliminating wound infections or at least sharply reducing the wound infection rate. Is there a recommended procedure available for controlling contamination that can be adopted by a hospital of 65 beds?—A.C., Ill.

ANSWER: Many hospitals of all sizes are presently experimenting to find ways of maintaining a truly sterile operating room. One approach, recently described in the literature,* reportedly was extremely successful in a 56 bed hospital. The procedure used at this hospital placed emphasis on "a high degree of cleansing and isolation."

Basis of the procedure, as reported in *RN*, is a series of four zones set up between the O.R. and the rest of the hospital. Zone A, comprising the two O.R. rooms, the sterilizing room and the autoclave area, is the sterile zone. Zone B, comprising the inner corridor where the scrub sinks are located, the stretcher room and the clean workroom, is classified as the interchange zone. Zone C, the clean zone, comprises the outer corridor, nurses' room and station, and the doctors' room. Zone D, the so-called dirty zone, comprises the rest of the hospital.

The authors report that when the scrub nurse arrives, she enters the clean zone (Zone C), hangs her street clothes in her locker and puts on her duty shoes. She then washes her hands and dons a sterile scrub gown and cap, and a fitted filter mask.

She next enters the interchange zone (Zone B) where a strip of detergent-disinfectant-soaked blanket is stretched on the floor just inside the entrance. Here she sits on a stool at one end of the blanket and picks up a pair of sterile conductive boots. After she puts them on over her duty shoes, she may move freely within the interchange zone.

Next, the nurse opens packs containing her gown, gloves and a supply of sterile brushes and cotton balls. She puts on a plastic apron and begins her scrub. (The authors point out that the waterproof plastic apron prevents any organisms from splashing on the nurse's scrub dress and later soaking through to contaminate her surgical gown. The circulating nurse, who has now arrived, removes the apron for her as soon as the scrub is completed.)

The scrub nurse does two five-minute scrubs, each with a separate brush. Then she soaks her hands and arms for 30 seconds at the rinse basin. She sponges them for another 30 seconds with a cotton ball dipped in the rinse solution. Finally, she dries them carefully and dons her operating gown and gloves.

She now enters the operating room (Zone A) and sets up the instrument tables. Meanwhile, other members of the surgical team arrive.

An outside aide brings the patient to Zone B (the interchange zone) on a ward stretcher and stops the stretcher on the detergent-disinfectant-soaked blanket. An aide inside the zone then dresses the patient in a sterile cap, gown, and mask. (A gauze mask is used because a filter mask would interfere with anesthesia.) The aide then transfers the patient to a clean stretcher that is always kept inside Zone B.

Neither the aide nor the ward stretcher is ordinarily allowed in the O.R., according to the authors. If a doctor orders his patient transferred directly from a recovery room bed to the O.R. table, the bed is scrubbed before it is brought in from Zone B. Any outside equipment is also scrubbed before it is brought into this zone.

Aides leaving the O.R. to get the patient must don fresh caps, gowns, masks and boots before reentering the interchange zone. The authors point out that anyone from the O.R. can go as far as the clean zone (Zone C); but this person must wipe his or her boot soles on the specially treated blanket before reentering Zone B (the interchange zone).

These rules apply to everyone. They are in force constantly. We believe, wrote the authors, "that the only way to ensure strict adherence to aseptic technic is to enforce all rules through constant supervision by an R.N. We believe that operating room supervisors — or, for that matter, supervisors of delivery rooms and newborn nurseries — are justified in practicing a friendly tyranny over the people who come into their domain."

*Adams, R. and Dube, E. M.: How We Stamped Out O.R. Staph, RN, 22:44 (May) 1959.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Does Blue Cross Over-Use

Question: One of our trustees who is interested in Blue Cross insists that Blue Cross patients use the hospital oftener than is necessary, and Blue Cross patients tend to stay in the hospital longer than other patients. He is suggesting organization of a medical staff committee to "police" Blue Cross. Others on the board agree with the administration that this is a radical step, and we have read that there is no proof of over-use of hospitals by Blue Cross patients. Are there studies showing what the facts are, and what medical staff committees can accomplish? —M.W.M., Idaho.

ANSWER: A recent study reported by the U. S. Public Health Service showed that insured (though not necessarily by Blue Cross) patients used the hospital more often than uninsured persons, and that the average hospital stay of the insured patient was substantially longer than the stay of the uninsured patient. Review committees have been established by the medical staffs of many hospitals in an effort to eliminate excessive use of facilities, but as yet there are no published reports showing what such committees have accomplished.

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HILL-BURTON EVALUATED

Back from a nationwide series of meetings with hospital and medical groups, Dr. Jack C. Haldeman, chief of the Hill-Burton program, reports that the industry now is well aware that better planning must go hand-in-hand with the increased construction that is in sight.

Dr. Haldeman and other Public Health Service officials met with hospital and medical groups in New Orleans, Salt Lake City, Chicago and Washington, D.C. He is chief of the P.H.S. division of hospital and medical facilities, which administers H-B at the national level.

"I noticed broad community and state concern over the mounting cost of hospital care," Dr. Haldeman told The MODERN HOSPITAL. "The industry now wants a critical examination of those areas where we suspect or know that there is inefficiency and duplication."

"Up to now," he said, "Hill-Burton is recognized, I think, as having done a good job in rural areas. These conferences seemed to be intensely interested in developing better planning for urban areas, and in finding some means of overcoming the economic barriers in the way of better and less costly hospital care in built-up areas, particularly suburbia where we are told three-quarters of the population growth will occur in the immediate future."

While 75 bed hospitals have their places in rural and in some suburban sections, Dr. Haldeman said there is no place for them in a city like New York. Nor should every hospital in a densely populated urban area expect that it should have a cobalt unit and all the other expensive facilities and personnel available.

"Flexibility in plans is essential," he said, "if hospitals are to keep their costs within reason and be prepared for inevitable expansion. At these meetings there were repeated references to the duty of hospitals to assume a broader role, looking into problems of long-term and short-term care and home care. It is now recognized that the hospital must build itself into the community and not price itself out of the community."

HILL-BURTON BILL ROLLS ALONG

The bill to finance Hill-Burton hospital construction for the next fiscal year is rolling easily through Congress. As finally approved, the figure may not equal the record $186.2 million being spent on hospitals this year, but it will be well above the $101.2 million the Eisenhower Administration thought would be enough.

As in the past few years, Congressional leaders are berating the Administration — particularly the White House and the budget bureau — for not asking more money to run Hill-Burton and other health activities. Toward officials of the Department of Health, Education and Welfare, the Democratic representatives and senators are showing patience and understanding. With them, their attitude is: "We know you want more money than you asked for, but you were turned down by the people at the top."

When the Senate appropriations subcommittee started hearings on the labor and health, education and welfare budget bill, Chairman Lister Hill took off after the Administration, but was lenient with Secretary Flemming and others from H.E.W.

Senator Hill noted that the House had increased money for H.E.W. by $181 million over the budget bureau request, for a total of $3.3 billion. He called this work by the House subcommittee, "an awfully good precedent," and recalled that for the last six years his own subcommittee had either accepted the House totals or given them a second increase.

"We realize your situation," he told the Secretary. "You are here as spokesman for your department, which is part and parcel of the Administration. It is your responsibility to defend the President's policy and budget."

Committee Member Dennis Chavez (D.-N.M.) added: "I don't see how when dealing with human beings you can worry about the budget. . . ."

At the hearings before Chairman John Fogarty's House subcommittee, held in private, the tone was the same. Through the witnesses from the department (Public Health Service and National Institutes of Health) Mr. Fogarty ripped into the Administration for submitting what he considered inadequate requests for Hill-Burton and research programs. But he saved some choice comments for the subcommittee's report, subsequently approved by the full committee and the House.

The report states that the committee is recommending $143.7 million for H-B, an increase of $42.5 million over the budget bureau's request. Then this observation:

"For this item, . . . the budget submission was so completely out of line with the obvious needs and demands for this program that it could not, under any circumstances, be accepted by the committee.

"The budget was based on providing only sufficient additional hospital facilities to take care of the increase in population and the loss of hospital facilities through destruction, such as by fire. There was no allowance made for replacing obsolete hospital facilities and there was no provision for making inroads into the enormous backlog of need that exists. The plans submitted by the state agencies administering this program estimated, as of Dec. 31, 1958, a total need for an additional 1,119,000 hospital and nursing home beds.

"For a nation that prides itself in not only being the most wealthy nation in the world but in putting the welfare of the individual on the highest level, it is unthinkable that we should continue to let a condition like this exist where people are deprived of good medical care when it is within our power to make it available to them."

In all of this speech making you can find a political undertone, as in past years. But the important point is that on

health matters Congress does just about what Rep. Fogarty and Sen. Hill recommend. The bills usually go through on voice vote and, if there is a roll call, only a very few conservatives are willing to stand up in opposition.

So, as Senator Hill virtually promised, the H-B appropriation will go through at very close to what it is for the current fiscal year.

Chairman Hill's hand is strengthened by the recommendation of the American Hospital Association that the full amount authorized, $150 million, be voted by Congress for the "regular" Hill-Burton program. A.H.A. had no recommendations for the new section — chronic disease hospitals, nursing homes, diagnostic-treatment centers, and rehabilitation facilities — except that Congress should be liberal in appropriations for nursing homes.

A.H.A. RESEARCH PROJECT

The American Hospital Association's proposed clinical evaluation of cardiovascular drugs (see The MODERN HOSPITAL, January 1959) now has been formally and officially put to rest.

Closed-door testimony before Mr. Fogarty's House appropriations subcommittee, now released, gives the explanation.

Addressing Dr. James Watt, director of the National Heart Institute, Chairman Fogarty bluntly opened the issue by asking: "What is the story on this grant to the American Hospital Association? Whatever happened to that? There are a lot of people talking about it. Some people blame you, some people blame the A.M.A., and some blame the hospital association."

Dr. Watt started the explanation, but it wasn't coming out fast enough to suit Dr. J. A. Shannon, director of the National Institutes. He summarized the situation:

"There are some other things I would like to put on the record so there is no misunderstanding about our relationship with Dr. Treloar (Dr. A. E. Treloar, formerly A.H.A.'s director of research) and the study going on or not going on.

"We approached Dr. Treloar last September and October, something in excess of two years after the grant was made, and at that time he had still been unable to get a suitably qualified principal investigator who would accept detailed responsibility for running of this study.

"At that time he had under consideration several individuals who conceivably could serve in that capacity. Two of the three later told me personally they would not accept the position.

"The fact that it seemed unlikely, then, that the study would get off the ground in the immediate future, and in fact might never get off the ground, led me to believe that Dr. Treloar's activities and his contribution to science would be much better in the position of review and analysis in the (N.I.H.) division of research grants.

"To my mind, I think that the difficulties, together with the passage of time, and the establishment of other studies . . . removed the urgency for the setting up of this study for which the grant had actually been in effect with no movement for two years."

New York Hospital Strike Spreads to Seventh Institution; 11 More Threatened

NEW YORK.—The strike against voluntary hospitals spread to a seventh hospital, Flower and Fifth Avenue, on the morning of June 5. Representatives of Local 1199, Retail Drug Employes Union, have also threatened to strike 11 additional voluntary hospitals.

Legal maneuvering, violence on picket lines and appointment by the mayor of a three-member board of investigation marked the third and fourth weeks of the strike.

The strike began May 8 when members of Local 1199 walked out of dietary, housekeeping, maintenance and nursing departments.

Union representatives claimed more than 1000 employes had walked out and hospital service was seriously impaired, but hospitals insisted the number of strikers was only a fraction of the total claimed by the union. Admissions were normal and service was uninterrupted, the hospitals added; new employes were being hired to replace workers on strike, volunteers were available in abundance, and strike-free hospitals were helping out in many departments, it was reported.

Leon J. Davis, president of Local 1199, and a business agent of the union were fined $250 each and sentenced to 15 days in jail by the Kings County Supreme Court for continuing the walkout at Brooklyn Jewish Hospital in defiance of a court order.

Five other hospitals (Mount Sinai, Lenox Hill, Bronx, Beth David and Beth Israel) obtained injunctions in Manhattan Supreme Court, barring the union from continuing to strike these hospitals.

Pickets Arrested

Two strikers at Brooklyn Jewish Hospital were charged with beating a nonstriking orderly on his way home from work at the hospital, and two pickets at Mount Sinai Hospital were arrested and charged with kicking policemen who were seeking to maintain order.

In a statement announcing appointment of the three-man board to investigate the strike, Mayor Wagner said the panel, which started immediately interviewing union and hospital representatives, would consider two basic principles involved in the controversy. These were:

1. That hospital employes should not strike.

2. That employes are entitled to an adequate substitute method of presenting grievances to their employers and making proposals on matters of wages, hours and working conditions.

Prior to appointment of the board, the union had turned down an offer of the hospitals to raise wages to $1 an hour, because the offer did not include recognition of the union as bargaining agent for employes.

A threatened strike against seven proprietary hospitals by Local 144, Hotel and Allied Service Employes Union, was postponed pending a National Labor Relations Board ruling on the question of whether the union represented a majority of employes in the seven hospitals. Officials of three of the hospitals have agreed to collective bargaining elections.

The Modern Hospital
JUNE 1959

LOOKING AROUND

Hospital Strike

FOR a union organizer, truth resides in the squalid tenement home of an underpaid hospital orderly, and virtue illuminates the acts of all who aim to improve his condition. For a hospital president, truth is the suffering of sick and injured patients, and virtue attends the entire enterprise devoted to bringing them care and comfort. For an observer in New York City during the second week of the strike against voluntary hospitals there last month, truth was a phantom that appeared, and vanished, and appeared again wearing new features. Virtue could be found in hospital wards and offices and kitchens and elevators, and in union halls and picket lines, but sometimes the image of virtue was blurred, like a bad television picture, and sometimes a faint shadow of evil could be seen moving at virtue's elbow.

In a strikebound hospital, virtue was plainly at the side of doctors who were carrying all their regular duties and responsibilities and performing many routine chores besides; and virtue was at the side of overworked nurses who got on with the job and got it done somehow with overtime and volunteers and green new help; and virtue was at the side of the countless volunteers who came forward quickly to work at strange, hard tasks on the wards and in the kitchens and corridors; and virtue was at the side of the strike-free hospitals that offered personnel, and services, and materials as needed; and virtue was at the side of administrators who planned and worked and conferred around the clock; and virtue was at the side of trustees who left their businesses and came to the hospital to watch and worry, and virtue was at the side of all these and many more because they were helping in God's work of healing the sick. But virtue looked the other way, in a strikebound hospital, when an administrator declared categorically that service to patients was "better than ever" — a barefaced lie; and virtue was embarrassed by a trustee who told a visitor that the striking union was led by labor racketeers, which is not the case; and virtue was shamed by the hospital's personnel record — a sorry history of mean wages and shabby practice.

Virtue listened patiently on the picket line at a strikebound hospital as a sad-faced Puerto Rican porter tried to tell a reporter what it was like for a family to live in New York City on $38 a week; and virtue sat at a desk in the union office as an earnest young labor publicist spoke his conviction that: "Unions are good for workers — no exceptions!" and virtue was at the side of these and many others because they were helping in God's work of raising the downtrodden. But virtue turned wrathfully away from a picket line where strikers roughed up a young man on his way to work in a strikebound hospital; and virtue was sickened when the earnest young labor publicist described hard-working, decent, public-spirited hospital administrators and trustees as evil conspirators; and virtue was far, far away when a labor representative self-righteously disclaimed any responsibility for interrupted or deteriorated service to the sick in the struck hospitals, because: "It was management's refusal to recognize the union that caused the strike."

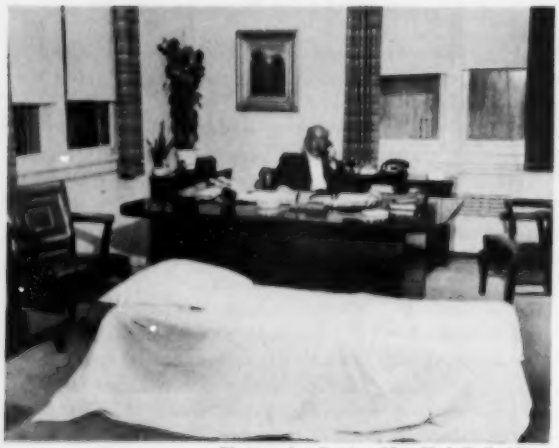
Whether leaders of labor believe it or not, management's refusal to recognize the union is solidly based on management's understanding that the hospital's obligations are unlike those of all other enterprise in our society — a circumstance acknowledged in law by exemption from the compulsory collective bargaining provisions of state and federal labor statutes. Its procedures may be similar at times, but the purpose of a hospital is as different from the purpose of industry as a church is different from a bank. The purpose of a hospital is patient care, and responsibility for patient care is indivisible. Whatever subtracts from management's authority in a hospital subtracts from management's responsibility and might at any time become a threat to the life or safety or comfort of patients — as the life and safety and comfort of patients have indeed been threatened, if not sacrificed, whenever a hospital strike has occurred.

Does recognition of a union of hospital workers necessarily subtract from management's authority in a hospital? New York hospitals say it does and for a time carried nonrecognition to the point of refusing to enter the same room with union negotiators — an inflexible position which cost them a measurable share of the public sympathy that flows naturally to the hospital side in a labor dispute. Unquestionably, most hospital people would agree with the New York view that hospital unions are a threat to hospital responsibility, and many would applaud the intransigeance that has been

mistaken for arrogance on the part of the hospitals. But there are some hospitals elsewhere which have dealt with unions for years and will testify that no loss of authority has occurred and no threat to responsibility exists. There are good and bad unions, according to this testimony, even as there are good and bad hospitals, and it is just as absurd to attribute the sins of bad unions to good unions as it would be to consider the Peter Bent Brigham Hospital an abortion mill.

Whatever hospital people think, it seems likely that hospital labor is going to be organized. What has happened in New York could happen wherever workers are ill-paid and hospitals are uncompromising, and there may be many such places. Some good hospitals may be hurt, as some good hospitals in New York and elsewhere have been hurt already, by bad unions, or bad tactics, or both. Where hospital people have the will and the wisdom to understand that they cannot serve the sick by debasing the worker, and where union leaders have the will and the wisdom to understand that they cannot serve the worker by harming and harassing the sick, it should be possible to develop some mechanism or agreement, short of an industrial union contract, that will protect the worker and safeguard the sick. Then truth will dwell on both sides, and virtue will shine unshadowed on all who are doing God's work of helping the sick and raising the downtrodden.

PICTURES TELL THE STORY OF STRIKE AGAINST NEW YORK HOSPITALS



Photographs, Courtesy New York Daily News.

ABOVE: INSIDE LOOKING OUT. Charles Gellman, director of Beth David Hospital, New York, in his office at the hospital. When the strike began, Mr. Gellman had the cot moved in and took up residence for the duration.

ABOVE: OUTSIDE LOOKING IN. A laundry helper, accompanied by her two-year old daughter, waits to take her place in the picket line in front of Beth Israel Hospital. Pickets' signs protest the hospital's salary scale.

Robert La Branche, publicist at the Lenox Hill Hospital, operates an elevator, while another member of the staff helps direct visitor traffic.

A member of the nursing staff of Mount Sinai Hospital at work in the hospital laboratory. Her volunteer assistant on the job is her mother.

Youngsters also serve as volunteers during the strike. Here, two students man the mops in the dietary department of Lenox Hill Hospital.

John P. Preston

This program, sponsored by the Hospital Council of Southern California, is open to all area hospitals. It is designed to bring order to a chaotic pricing structure and to make charges understandable to patients

Uniform System of Charging Is Accepted by 94 Hospitals in Southern California

W. Glenn Ebersole

Percy F. Riggs

Samuel G. Tibbitts

LOS ANGELES. — Hospitals in Southern California are busy restudying their costs and altering their daily service and other basic charges to conform to a new program that will go into effect June 30.

Purpose of the program is to make hospital costs and charges readily understandable to patients.

The program, based on procedures and recommendations known as the "Guiding Principles for Establishing Hospital Charges," will result in a uniform system of charging for hospital care — a system related to the cost of furnishing that care. Considerable shifting of charges is expected.

For example, some participating hospitals have already reported a decrease in their ancillary charges and a corresponding increase in charges for room and board, now referred to as the daily hospital service charge.

To date, 94 hospitals in the Southern California area have agreed in writing to comply with the principles. Although the program is sponsored by the Hospital Council of Southern California, all hospitals in the area — whether members of the council or not — were invited to participate. Those complying include voluntary, proprietary, split staff (M.D.'s and osteopaths), osteopathic, district and county hospitals. According to John P. Preston, past president of the council and director of Inter-Community Hospital, Covina, the 94 hospitals already enrolled represent more than 70 per cent of all hospital beds in the area.

The program does not establish uniform charges. Nor does it set rates. It does, however, go beyond a statement of broad principles and outline specific procedures designed to establish uniformity of method of charging.

The Principles

Here, in brief, are the principles underlying the program:

1. Only services ordered by the attending physician or routine procedures established with medical staff approval are charged to the patient. Charges for professional services rendered by physicians or special duty nurses are not included. These charges may be billed separately by the person providing the services or by the hospital acting as a billing agent. *(Continued on Page 66)*

2. Government and voluntary community agencies should pay the full cost of contracted hospital services.

3. Hospital rates should be based upon and reasonably related to the full cost of operation. They should include proportionate overhead costs, such as laundry, linen, housekeeping, engineering, maintenance and repair, admitting, accounting, depreciation, insurance, taxes, utilities and similar items.

4. A general service charge should be established for all commonly used services and supplies provided in relatively equal quantities to patients.

5. Premium rates may be established for de luxe accommodations, *i.e.* accommodations in excess of those required for hospital care or for privacy.

6. Uniform unit rates should be established for special or ancillary services (such as laboratory, x-ray, pharmacy) and for supplies that are not provided in relatively equal amounts to all patients. These unit rates are only for services and supplies that cost enough to justify making a separate charge. To simplify the rate structure, units may be combined into a flat rate.

7. Regardless of the source of reimbursement, hospitals must furnish an accounting that is readily understandable to each patient. Where special gifts, endowments, grants and tax subsidies have been designated specifically to underwrite the care of patients, such income should be used for its designated purpose and amounts allowed to the individual patient should be indicated on each account.

8. Each hospital accepting these principles must make available to patients an explanation of what is included in its own daily hospital service charge and other charges.

(Participating hospitals must agree to maintain at the business desk a standard loose-leaf book listing all services included in its basic charges. This list must include services for which separate charges will not be made as well as those services for which a charge will be made.)

Their Implementation

These principles have been implemented by a specific method of setting charges. All hospitals subscribing to the program, for example, have agreed to the following listing of items and services that will be charged to the patient on a standard basis.

Daily Hospital Service. This term replaces the phrase "room and board." The change was made because of the inadequacy of the phrase "room and board" to describe the basic services offered daily to each patient. Daily Hospital Service, based on a 24 hour day, includes:

1. Room, complete linen service, meals, therapeutic diets, and nourishments.

2. General nursing service and services of trainees — interns, residents and student nurses.

3. Medical record and admitting service.

4. The use of hospital equipment and instruments, such as thermometers, proctoscopes, laryngoscopes, blood pressure apparatus, gloves, tongue blades, and similar items used for the examination of patients.

5. Treatments such as Sitz baths and infrared lamp treatments which are not provided through the physical therapy department.

6. Routine drugs such as aspirin; drugs of the acetylsalicylic acid family including APC Compound and Empirin Compound.

7. Simple laxatives; merthiolate and similar antiseptics.

8. Routine supplies such as cotton balls, cellulose wipes, syringes, needles and maternity pads in the maternity department.

9. Hot bags, frozen bags, and rubbing alcohol.

10. Administration of medications.

The foregoing services are included in the nursery charge for newborn infants.

Pharmacy Service. Pharmacy charges include the cost of drugs prescribed by the attending physician and the services of registered pharmacists and other pharmacy personnel.

A Lawyer Looks At the Program

James E. Ludlam

As legal counsel for the California Hospital Association and its spokesman before legislative committees, I have been faced with the fact that the public and its representatives do not understand the problems faced by hospitals in maintaining an ever improving quality of care during a period of spiraling costs. This problem is made more acute by the existence of many hospital charges that are obviously unrelated to cost as well as "nuisance" charges that have been developed on a hit-or-miss basis in order to avoid increasing the room rate. The wide variation in the basis for charging has only confirmed the suspicion of many that hospitals are not only unbusinesslike but are actually engaged in highly questionable practices.

Our success in overcoming these impressions will be immeasurably improved by the voluntary adoption of "The Guiding Principles." Both the legislature and the public have great sympathy for an industry that is really attempting to resolve its own problems. Testimony showing positive action is worth a thousand letters and telegrams on the negative side.

The hospital council committee has made a major contribution in strengthening the hospital position and standing in this state, provided that its program receives the unqualified support of its members, which is apparently forthcoming.

James E. Ludlam is legal counsel for the California Hospital Association.

Drugs should be charged at no more than the average retail price for which they could be purchased in the same dosage at a pharmacy in the community.

Central Service. Central service includes the cost of supplies and the cost of preparing, handling and storing the supplies.

There may be a separate charge for treatment trays, dressings and the use of equipment as ordered by the attending physician.

Operating Room Service. The operating room charge is based on the amount of time the patient is in the operating room and upon the type of operation. Major operations are more costly than minor operations in terms of labor, supplies and equipment. The operating room charge should reflect this difference in cost. The charge includes:

1. The services of qualified technical personnel.
2. Linen, instruments, equipment and routine supplies such as sutures, gloves and bandages.
3. The use of the recovery room.

There may be a special charge for nonroutine surgical supplies such as hip pins, bone nails, bone plates, tantalum mesh, and so forth, including the cost of preparing, storing and handling such supplies.

A separate charge may be made to cover the cost of anesthetic supplies used during the operation.

Delivery Room and Labor Room Service. The delivery room and labor room charge is a flat rate charge. It includes services of technical personnel and use of equipment, anesthetic supplies, routine drugs and supplies, and linen used in labor and delivery rooms.

Professional Service. X-ray, physical medicine, laboratory, electroencephalography, electrocardiography, and so on, are professional departments and the fee, as charged, should be based upon the usual and customary charges in the area. As a method of simplifying billing procedures and as a convenience to patients, it is recommended that this fee be assigned by the medical specialist to the hospital for collection. This procedure has been approved by the California Medical Association and the California Hospital Association.

Blood Transfusion Service. The supplying of blood to patients is a service and not a sale. A responsibility fee deposit may be requested to assure the replacement of blood and to cover any losses the hospital may suffer when it is necessary to purchase blood from private blood banks. If a deposit is required, the full amount of the deposit will be refunded when the blood is replaced.

Laboratory work such as typing, serology and cross-matching required in the processing of blood will be charged separately in the same manner as other laboratory services.

The hospital may make a single charge for the storage, handling and administration of blood.

Personal Service. Personal services such as telephone calls, guest meals and personal purchases will be charged separately on the patient's account and so indicated.

A continuing committee of the Hospital Council of Southern California has the right, after due hearing, to recommend to the board of directors removal of any hospital deviating from the principles. A plaque is provided each hospital that accepts the principles.

An Administrator Looks At the Program

Ritz E. Heerman

This program is one of the first attempts by hospitals outside of the Joint Commission on Accreditation of Hospitals to set standards for hospital operation and to provide for the control of these standards on a voluntary basis. A basis for uniform rate structures is something that many of us have been promoting for years. The ramifications of such a program are many; among them are:

1. It produces a greater understanding of hospital charges by consumers.

2. It allows for more efficient actuarial study, thereby producing better insurance coverage for the patient.

3. It provides standards by which grievances can be adjudicated.

4. It strongly indicates to the public that hospitals are capable and sufficiently interested to not only increase standards of hospital care, but also to control hospital charges through uniformity and joint action.

I believe that although this is just one more positive step in the direction of maintaining and expanding the voluntary hospital system, it is extremely significant when combined with uniform accounting and comparative cost reporting. Further, there is evidence in Southern California that this program will not only beneficially affect member medical hospitals of approved organizations, but also other hospitals in the community. Last, there can be no doubt that if such a uniform program were in effect in all states of the union, such incidents as we have had in Pennsylvania, Maryland, and so forth, might not have happened.

Ritz E. Heerman was executive vice president of the Lutheran Hospital Society of Southern California before his death on April 21. He had been active in this program since its inception.

The Beginning

The program owes its origin at least in part to the tremendous increase in hospital facilities in Southern California. The number of hospitals in this area has more than doubled in the last 10 years. During this expansion, hospitals emphasized quality of care at the expense of relating indi-

vidual charges to actual costs. Room and board expenses steadily mounted, as elsewhere, and charges for these items were related more to going local rates than to their actual cost.

The absence of a standard system of charging in a period of great growth enabled a few hospitals to take advantage of the need for care by overcharging. This, as always, was difficult to prove. Differences in methods of charging for similar services in different hospitals confused patients. There appeared to be no criteria on which to judge complaints about charges from the public.

Studies undertaken by insurance companies and Blue Cross disclosed an excessive spread in costs for routine hospital services. Studies of tonsillectomies in 232 hospitals, for example, showed charges varying from a minimum of $41.86 to a maximum of $144.59.

In 1956 the hospital council organized an education and grievance committee to study the situation. The committee, under the chairmanship of the late Percy Riggs, former administrator of Hollywood Presbyterian Hospital, Los Angeles, found that charges for room and board were accounting for less and less of the total bill in many hospitals. Welfare funds indicated that payments had shifted from the former ratio of 50 per cent for basic charges and 50 per cent for ancillary charges to a ratio sometimes as high as 70 per cent for ancillary charges and 30 per cent for basic charges.

Items and services that were formerly included without special charge in the daily rate were moving over and appearing on the patient's bill as special charges. This marked an attempt by some hospitals to offset increased costs without raising the charges for room and board above the going rates of other hospitals in the area.

After two years of study, the committee recognized the need for a basic change in charge patterns. In the words of Samuel Tibbitts, present chairman of the committee and superintendent of California Hospital, Los Angeles, "The magnitude of the problems convinced the committee members that only a broad, frontal, fundamental approach could change the situation and put us in a position to tell the real story of hospitals and obtain increasing public understanding and confidence. This approach called for a complete set of operating responsibilities and ethics plus uniformity of relating charges, as set by each hospital, to the actual costs in that hospital."

A Physician Looks At the Program

This is a very realistic and constructive approach and has been long overdue. I think the public doesn't object to charges when they realize the charges are legitimate. The public will now have an awareness of what they are getting and what elements really constitute the cost of hospitalization. This will be very helpful to doctors in explaining to their patients the services included in hospitalization.—

William Quinn, M.D., president, Los Angeles County Medical Association.

Set Target Date

On Nov. 6, 1958, the recommendations of the committee were approved by the board of directors of the hospital council. A target date of June 30, 1959, was set for putting the complete project into effect.

Hospitals in the San Diego area have now made acceptance of the principles a condition of membership. In addition, the directors of the Hospital Council of Southern California have voted that, within three years, acceptance of the principles will be a condition of membership in the council.

Insurance companies have been watching the plan closely and endorse its objectives as well as its approach. They have proposed gradual revisions of their large group contracts as soon as the average increase in daily service charges with concomitant reductions in ancillary charges are reported by accepting hospitals. Spokesmen say they anticipate that 18 months may be required to complete their renegotiations.

Blue Cross Backs Plan

Blue Cross of Southern California has also encouraged the program by donating time and facilities, although members who receive the service type of hospital coverage are not appreciably affected.

What results do the participants of the plan anticipate? Nothing spectacular in the area of cost reductions — at least, not yet. Says Glenn Ebersole, executive director of the Hospital Council of Southern California, "There is no claim or expectation that this program will reduce the legitimate costs for hospital care, especially at its outset. The program is the first step toward making costs understandable to all elements involved. It will provide a basis for evaluation or comparison between hospitals, help prevent even the small potential abuse by a few, and explain why hospital services plus charges for professional services ordered by the physician create necessarily a larger patient bill than the room and board charge the patient has too often been quoted in advance."

Although cost relief may not be a direct result of this collective venture, those who have been working with the program say that it will

— provide a healthy influence on hospitals whose costs are now out of line;

— provide a standard form for charging for hospital services that will make a hospital bill easily understandable;

— help refute charges that hospitals and Blue Cross are doing nothing about the high cost of hospital care;

— provide greater benefits for individuals enrolled in commercial insurance plans that provide relatively low room and board benefits. ■

Rules That Bend Aren't Often Broken

Efficiency in the hospital is not so much to be desired as effectiveness, suggests the author. What's more, he points out, the best way to obtain effectiveness is to give a little here and there rather than hang on to hard and fast regulations that provide no wiggle room

S. G. Hill

NO MATTER how great the variations may be between the many types of administrative enterprise, one feature they have in common is the human relationship that arises from a number of people working in association. The most familiar pattern is, of course, that of the employer and employe or "master and servant," but other patterns occasionally arise.

One such pattern, for example, occurs when a number of people are working together in capacities of equal status and by coordination and cooperation rather than by command and instruction. Such a pattern is not very common. Even where it exists, it is usually subject to the doctrine of "*primus inter pares*" whereby one of the equal partners assumes a position approximating leadership for the purpose of the enterprise and becomes in effect "first among equals."

Both the relationships of "master and servant" and also "*primus inter pares*" find their place in the hospital world. The former relationship is more important and demands more attention, but the latter relationship is frequently found among hospital senior medical staffs, and its existence must not be ignored.

From the simpler and more frequent "master and servant" pattern it is possible to adduce certain principles which should be observed and which, if neglected, will cause serious personnel disturbances and defects within an organization.

First, there is no doubt that the keynote of staff control must be fairness. This must come before ways of ensuring efficiency as such, because in the long run human beings will not react efficiently unless they are treated properly, which, in the circumstances of employment, means fairly. Personal favoritism and personal prejudices must not form part of any chief officer's attitude toward his staff.

If members of the staff feel that their success in the enterprise depends upon the uncertainties of the chief officer's personal attitude rather than upon their merits, they are bound to feel insecure. This in turn will detract from their performance. Furthermore, the more efficient officers will constantly seek to move elsewhere to find more stable conditions where their merits receive proper recognition.

Close to Efficiency

An aspect of fair treatment must be the encouragement of initiative, and here we are coming closer to considerations of pure efficiency. Although it is probably true that industry and commercial undertakings have more to gain from the individual initiative of employes than, for example, the hospital service, nevertheless there is no undertaking that is incapable of improvement at some point or another from action and ideas emanating not from the chief officer, but from those whose normal function is to obey rather than to give instructions.

Every organization should create an atmosphere in which ideas may readily permeate upwards and in which members of the staff are encouraged to take initiative (within reasonable limits) and not always to await instructions from above. This implies a willingness on the part of management to receive with patience a number of worthless suggestions and to overlook, or at least not to reprimand too harshly, actions taken by subordinates that lack maturity and judgment. There is, of course, room for the personal preference of the individual chief officer. One chief may prefer to give his staff more precise instructions, leaving less room for initiative and risking fewer mistakes, while another chief may prefer to issue only general instructions, giving his staff plenty of scope for using initiative and, incidentally, for making a fair quota of mistakes. No one probably can determine precisely where the line should be set, but a dynamic organization, such as a hospital, ought to leave room for initiative at most levels. In general, it is impossible to foresee the many possible happenings and developments in hospital administration. Therefore, it is unwise to attempt to plan to meet every contingency. Whether the de-

Mr. Hill is secretary, Northampton and District Hospital Management, Northampton, England.

This is the fifth in Mr. Hill's series on general principles of administration. The first four appeared in the September, October, November and January issues of The Modern Hospital.

The cook who drinks may be replaced by a cook who can't cook

gree of initiative is small or large, it is important that each officer know when to obey instructions and when to act upon his own initiative.

Difficulty sometimes arises because of uncertainty as to what standard may reasonably be expected of various categories of workers. While this standard varies according to the type of worker concerned and according to labor conditions and other factors, it should always be remembered that perfection is not likely to be encountered. Hence, chief officers have to learn to settle for something less in their employes just as, it is hoped, a beneficent organization will apply similar principles to them. How much less than perfection constitutes a reasonable standard again depends upon so many factors that quantitative measurement is impossible. This point usually becomes relevant when the question of some misdemeanor arises.

In assessing general standards, the employe should be assessed as a complete individual without too much emphasis upon the incident that gives rise to the assessment. It may be that Mr. X has a tendency to be rather late, but it may also be true that Mr. X is a loyal and competent worker who never minds working late if necessary. Nurse A may be rather careless and may have narrowly avoided making a serious mistake in the administration of a drug, but Nurse A may also be extremely kind to the patients and may inspire in them confidence which is not evoked by more efficient and less careless nurses. This is the sort of equation that must be looked at before too readily dismissing Mr. X for unpunctuality and Nurse A for carelessness. Before he dispenses with the services of those employes who have failed in some particular, the chief officer must always ask himself what will be the caliber of the employes with whom he replaces them. This might seem highly materialistic and a somewhat cynical calculation, but it is an extremely relevant one and one which is not made with sufficient frequency. Too often the cook who is a little too fond of liquor is replaced by the cook who can't cook. It is mere prudence to take steps to prevent this from occurring. A major consideration in this matter is, of course, external labor conditions, and very real problems arise where (as in some cases in Great Britain) palpably substandard labor has to be retained because labor of higher efficiency would probably not be obtainable. This unfortunate aspect of the matter does not, of course, invalidate the general principle enunciated.

As it is with standards of performance, so it is with standards of general behavior and discipline. The degree of discipline appropriate to an undertaking varies with the nature of the undertaking and also with the traditions and outlook (national as well as local) of the particular organization. Discipline appropriate to the armed services is usually regarded as of a high standard, though this varies among the nations. On the other hand, a factory, works or commercial undertaking probably needs very little discipline in the usual sense and rests solely upon a general understanding that it is the management's job to hire and fire the workers and that workers are expected to carry out instructions issued, for technical rather than moral reasons. A hospital probably comes halfway between these two extremes. First, so far as nurses are concerned, many hospitals are also schools and, therefore, a degree of academic discipline is necessary. Also, as most student nurses are relatively young, a measure of parental discipline is also appropriate. So far as nurses and all other employes are concerned, a measure of discipline is necessary because of the urgency and importance of much of the work.

If a doctor orders a patient to be taken to the operating theater for an immediate operation and requests that x-rays and laboratory tests be made

What Happens When Principle Meets Principle

One problem of particular difficulty that may be encountered in any type of organization and is sometimes incapable of satisfactory solution is the problem that arises when a departmental chief has acted hastily or unjustly toward one of his subordinates and the matter is referred to the chief officer by either party. Two excellent principles of administration are here diametrically opposed. First, the principle that the chief officer should do justice to all, and second, the principle that a chief officer should uphold the actions of his lieutenants. This type of conflict cannot really be settled satisfactorily in principle and one must fall back upon degree. If the miscarriage of justice or the situation of unfairness is of a minor character, then the chief officer should probably support his lieutenant in the presence of the subordinate officer, though he might explain in private to the lieutenant that he has acted mistakenly and that on any future similar occasion his action will not be upheld. If the subordinate feels particularly aggrieved, the chief officer might explain that no organization can safeguard its employes against what appears to them to be minor injustices and miscalculations and that they must take the rough with the smooth in all walks of life. If, however, the lieutenant has been a party to some substantial miscarriage of justice, then the chief officer cannot support him, though he should point out to the subordinate the difficulties that accompany the responsibilities of the lieutenant and he should do what he can to minimize the damage that has been done. ■

The elastic approach is often preferable to cut and dried discipline

available beforehand, it is important to the patient's cure that these instructions be precisely complied with. Similar considerations may not attach to a works manager's request that a consignment of goods should be moved by a certain time. General efficiency and courtesy should be sufficient to ensure compliance with the works manager's instructions, but these qualities are not reinforced by considerations of life and death which so often support similar apparently simple instructions in a hospital.

It is, perhaps, because hospital discipline has to be somewhat stricter than in some other organizations that it is important that disciplinary measures should be strictly related to what is necessary and should never extend into the realm of gratuitous interference with, and restriction of, the individuality of the employe. The allegedly rigid and unreasonable conditions applied to the nursing staffs of some hospitals has been a familiar subject of criticism. It is true that, in some hospitals, conditions constituted an unnecessary interference with the private affairs of the nurses, and prohibitions against friendships with other members of the staff (even more senior members of the nursing staff), and severe restrictions on personal liberty were difficult to justify. It must be remembered, however, that many of these rules belong to an age when the entire body of social outlook and opinion was very different from what it is at present, and it is most unlikely that unsatisfactory conditions of this nature are any longer encountered in English hospitals. The principle, however, is clear: Discipline should never go beyond the point which is necessary to assure the proper performance of the work of the hospital and the orderly conduct of life in the hospital community.

Administratively speaking, in the field of discipline and regulations, there is generally a choice between cut and dried conditions, on the one hand, and some degree of elasticity, on the other. For example, an employer may take the view that because he never expects his employes to work late, he is entitled to insist that they are punctual in reporting for work. On the other hand, it is equally valid for an employer to say that he will not be fussy regarding a few minutes lateness or the granting of an hour or two off duty, provided the necessary work is done, even if this involves extra time on the part of the employe. Although it has the obvious dangers of uncertainty and ease of abuse, the second, more elastic, approach is probably more appropriate to the work of a hospital than the more rigid precise one.

When Not To Forgive

Each chief officer will probably have his own assessment of the seriousness of the various misdemeanors that might be committed by members of the staff. Some chiefs can accept quite costly errors of judgment without violent reaction, but are moved to frenzy by minor inaccuracies arising from thoughtlessness or carelessness. In a hospital, the outcome of carelessness and mistake may be much more serious than in some other spheres, and so the value of careful work must be inculcated at every level. Anything involving dishonesty and lack of integrity must be dealt with severely. Second chances for such offenses cannot often be justified. Discourtesy and lack of consideration for patients should be placed high on the list of serious offenses — much higher than might be the case in other organizations. There is never any excuse for lack of courtesy and therefore the offense is an unnecessary one. In addition, people in the hospital are particularly in need of comfort, assurance and security. They are almost without exception in a condition of low morale and they are in a world that is extremely unfamiliar to them, though it is, of course, quite familiar to members of the staff. Accordingly, a brusque word or impatient comment can do much more harm to a patient than would be the case in other walks of life, and so kindness, consideration and courtesy to patients and to all other persons within the hospital should be insisted upon by the chief officer. He cannot, of course, make impolite people courteous, but he can ensure that the consequences of discourtesy are uncomfortable.

The extent to which the private life of the hospital employe should be any concern of the hospital management poses a number of difficult social and ethical issues. While in general the hospital, like any other employing authority, must be concerned primarily with the work of the officer at the hospital rather than with the behavior of that officer away from the hospital, nevertheless the hospital cannot entirely ignore lapses in standards of behavior of its officers even when away from the hospital, as to do so might bring the hospital itself into disrepute.

Traditionally, hospitals are supposed to have concerned themselves too much with the personal affairs of their nurses, and relaxation in some former regulations is justified. It is obvious, however, that no hospital should completely ignore departures from commonly accepted standards of behavior on the part of members of its staff where such departures are notorious and obvious. Short of this, all hospital employes should be entitled to live their lives in their own way without interference or censure from their employing authority.

Who Should Do What

Certain obvious principles should govern the deployment of staff and the selection of staff for particular assignments. Most human beings will work best at jobs they most enjoy. Within the narrow confines of an office or hospital department it is frequently possible to allocate work to some extent according to the preference of those who perform it. There are no particular rules for this; rather it is a matter of realizing that it is a good thing to fit square pegs into square holes and to develop a personal technic for doing it.

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Special reports on two regional meetings

Big Issues

Union Official Rebukes Group Practice Critics; Says It's Not the Principle, It's the Money

CHICAGO. — Fireworks were on display at the Tri-State Hospital Assembly here last month when a United Auto Workers spokesman sent up an incendiary-laden salvo that splattered against the fee-for-service system and "the holdout wing of the American Medical Association."

U.A.W. Vice President Leonard Woodcock supplied the fuse in a paper supporting hospital-centered group medical practice as the surest method to meet community health needs.

The paper was read by James Brindle, director of U.A.W.'s social security department.

"Group practice," Mr. Woodcock said, "is a form of heresy only in some medical circles." But, he added, there is evidence that the hard core of resistance in the A.M.A. to medical economics is softening.

"The hospital," he said, "is the best site for medical practice. It is the place where the quality of care is most susceptible to control and enhancement."

Warming up, he added, "And, fundamentally, it is the place where only those who are attempting to defend unthinkably high incomes; those who do not want to submit to reasonable controls; those who fear scrutiny, and those who do not want to accept the advance of modern medical science and technology have legitimate grounds for fear."

Mr. Woodcock said Sen. Wayne Morse's pending congressional investigation of medical care costs may help clarify the situation and wipe out fears planted by the holdout wing of the American Medical Association.

"It may take a public hearing," he said, "to show that when some pathologists, radiologists and anesthesiologists talk about fee-for-service prerogatives in resisting being on the hospital payroll, that what really is involved is an effort to obtain and preserve an entirely inordinate 'take.'

"It's not the principle of the thing," he said, "it's the money. What is involved in many cases is profiteering in a monopoly status that many of these specialists enjoy in large hospitals. It may be a healthy thing to have the Senate subpoena some of the contracts of specialists with hospitals to see what is really at the heart of a controversy now cloaked in pseudo-ethical terms."

Below: First-day mob scene at Tri-State registration desk prophesies large attendance—over 8000.

Statue of Brigham Young dominates the scene in Salt Lake City, Utah

Examined by Dr. Nelson

CHICAGO. — A refreshing change from convention orators who list the problems confronting hospitals and then hide the solutions behind an impenetrable wall of cliches was provided by Dr. Russell A. Nelson at the opening general session of the Tri-State Hospital Assembly. Dr. Nelson is president-elect of the American Hospital Association and director of Johns Hopkins Hospital, Baltimore.

The three-day meeting, April 27 to 29, sponsored by the state hospital associations of Illinois, Indiana, Michigan and Wisconsin, attracted an estimated 8500 persons, who found the wet, raw Chicago weather more conducive to exhibit-seeing than sight-seeing.

Instead of warmed-over truisms suggesting that everything will be all right if hospital people relax and stand still, Dr. Nelson served up a provocative and at times controversial mixture of ideas and suggestions.

Here are key points from Dr. Nelson's presentation, a presentation based, as he put it, "on ideas and judgments from my own experience."

— Radiology and pathology departments should be kept within the hospital and under Blue Cross.

"Because of the basic medical nature of their services," he said, radiologists and pathologists must be accorded the dignity and respect given other members of the medical staff. But, he cautioned, "we must be firm in our resolve to continue these services within the hospital and under Blue Cross — even under extreme pressure."

This arrangement must remain, Dr. Nelson said, because "it strengthens the hospital organization and because it provides these services at the lowest cost to the public."

— More controls for hospitals lie ahead.

"The ominous major implication of the recent public hearings is that more controls are in the offing for hospitals," he said, and the threat of these potential controls must be met. These controls, he added, are likely to come "through insurance commissioners, who control payment devices and consequently control the quality of care. The end result would be state control of the voluntary hospital system."

"If external controls are brought to bear on hospitals," he said, "the ultimate result will be a limiting of services."

What is needed and needed now, he suggested, is a program for self-control. The mechanism for such a pro-

Western Program Features Lecture on Leadership, Report on U.S.S.R. Hospitals

SALT LAKE CITY. — The 29th annual convention of the Association of Western Hospitals here last month got under way with a short history of western civilization. The historian was President Ernest L. Wilkinson of Brigham Young University, Provo. In a wide-ranging lecture on administrative leadership, Dr. Wilkinson at one time or another quoted or referred to Julius Caesar, Justinian, Henry II, Calvin Coolidge, President Eliot of Harvard, Napoleon, George Washington, Franklin D. Roosevelt, Senator Smoot, Senator Smoot's grandfather, Abraham Lincoln, Secretary Seward, Thomas Jefferson, James Madison, President Monroe, President Eisenhower and Brigham Young, "under whose leadership the desert came to blossom as the rose."

These and other leaders demonstrated the essential qualities for strong administrative leadership, according to Dr. Wilkinson, who said the strong administrator must be realistic, decisive, confident, inspiring and dedicated.

Demonstrating endurance, the audience then heard Professor James A. Hamilton of the University of Minnesota plead for more fact and less opinion in administrative acts and decisions. Hospital administration includes too much imitation and too little research, Professor Hamilton said. "If we want to be a profession with our own body of knowledge, we must start now to record the facts of our experience," he warned.

The facts about hospitals in the U.S.S.R.

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gram, he said, "exists in our state hospital associations, which can provide urgently needed controls."

– Hospitals must not relinquish their authority to the government.

"Hospitals," said Dr. Nelson, "must give up a little sovereignty to each other, but they must not relinquish their authority and sovereignty to the government." What is needed, he said, is something the government cannot provide – locally based administration that "really knows the health needs of individual communities."

– A new system of hospital-physician relationships must be developed.

"The traditional role of the physician in the hospital must be assessed," he said. "We have been operating the 1920 version for too long."

Trouble is, he said, that wherever this reappraisal of the relationship is suggested, "there are the usual cries of hospital domination, regimentation, third-party intervention and salaried medicine." Hospitals, he added wryly, "should be concerned but not regulated by these outcries."

A.C.H.A. Plans "Who's Who" for Publication in 1960

Those of us who are wondering who's who in the hospital field have only to wait until next year. A "Who's Who in Hospital Administration" is being undertaken by the American College of Hospital Administrators, it was announced by Ray E. Brown, A.C.H.A. president-elect. In a summary of the College's projects for the coming year, presented at a luncheon conference of the A.C.H.A. held in conjunction with Tri-State Hospital Assembly, Mr. Brown said that the book is scheduled for publication sometime in 1960.

In the past, Dr. Nelson said, the physician has been set apart from the hospital's administration. Now physicians are often considered "guests in the hospital privileged to serve patients."

The simple division of "medical affairs managed by physicians and management affairs managed by the administration is really not so simple," he said. "Physicians must have more responsibility and authority in the day-to-day operation of hospitals."

He suggested that physicians should be called upon to make economic as well as medical reviews and listed four ways to bring doctors closer to the hospital and provide them with background information on economic decisions.

1. Physicians on boards of trustees.
2. Physicians appointed to administrative offices.
3. Special medical committees organized on economic matters.
4. Changes in the charges and responsibilities of existing medical staff committees so that they can officially consider hospital economic matters.

– Collective bargaining should be kept out of the hospital.

"Hospitals have a responsibility to keep collective bargaining out of the hospital," he said, speaking particularly of nursing personnel, "for it is not profits, nor management, but critically ill patients who may be harmed."

– Health needs of the aged must be met.

Existing hospitals, said Dr. Nelson, "are not ideal places for medical care of the aged. Other institutions are needed under the sponsorship of hospitals."

Although he did not rule out the possibility of government intervention in this area, Dr. Nelson said that no federal action should be taken until prepayment plans have had every chance to solve the problems of financing the health needs of the aged. "Voluntary prepayment plans, hospitals and the medical profession must show that they can meet this challenge," he said.

– Research in hospital administration is needed.

Research in better hospital management is certainly needed, Dr. Nelson said, along with new ideas in communications. "Here," he said, "hospitals and government have an effective relationship. The estimated research in hospitals will total $1 billion by 1970 with the government contributing the greater share."

The growing significance of research in hospitals was also examined "in crude financial terms" by Dr. Aims C. McGuinness, who preceded Dr. Nelson at the lectern. Dr. McGuinness, special assistant to the Secretary of Health, Education and Welfare, said that a recently concluded survey disclosed that "about 1100 hospitals were doing research in 1959. Roughly 700 of these," he said, "were in the 'small beginnings' " stage with under $25,000 in research. Nearly 200 more were in the $25,000 to $100,000 range, he said, and more than 160 had research programs in excess of $100,000.

Blue Cross is providing 34 per cent of patient income for hospitals today, Richard M. Jones, director of the Blue Cross Commission, Chicago, told a Tri-State symposium on small hospital problems. Twenty-nine per cent of patient income is from patients and families paying their own bills, Mr. Jones added. Other sources are: commercial insurance, 26 per cent; government, 6 per cent, and other sources, 4 per cent.

For most hospitals, the practical effects of the growth of insurance have been to stabilize sources of revenue, increase paper work in the office, and replace the credit department with an insurance clerk, Mr. Jones said.

Small hospitals definitely can afford punch-card accounting, Douglas M. McNabb, administrator of the Emma L. Bixby Hospital at Adrian, Mich., told a conference on hospital accounting. A complete punch-card installation at his 124 bed hospital has not actually effected economies, Mr. McNabb acknowledged. However, he pointed out, better control of accounts receivable made possible by the mechanical accounting system had resulted in savings.

The most important value of the mechanical accounting method is in the administrative controls it provides, Mr. McNabb said. "The punch-card system talks back to management," he stated. Among the results of the installation at the Bixby Hospital, he listed:

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Aphorisms from the conventions

MANAGEMENT by exception is one of the best ways to run any business. Why worry about the normal or current accounts when you should actually be concentrating your efforts on those accounts that appear to be in trouble?

THEORETICALLY speaking, any clerical operation can be mechanized. Practically speaking, a large portion can be mechanized. Economically speaking, only a few can be mechanized. The question is not "how to mechanize" but rather "what to mechanize."

THE purchasing agent who is consistently in a legal hassle over contracts with suppliers is no credit to his institution or to the purchasing profession.

WE MUST be fully aware of and quickly correct an old and persistent notion that long-term or chronically ill persons are all in the older age bracket. As a matter of fact, approximately 16 per cent of persons with chronic disease are under 35 years of age.

A PRACTICAL approach to the preparation of a news release is to study the newspapers. Find out how other similar events have been written up, then write your own using the others as a model. Enlist the aid of a professional when you have a really important event.

IT HAS been said, "Use the law and physic only in case of necessity. They that use them otherwise abuse themselves into weak bodies and light purses; they are good remedies, bad recreations, but ruinous habits."

WE OFTEN assume that because we in administration know what is going on, our hospital family knows it too. That can be a dangerous assumption.

THE obstetrical department is frequently the orphan child of the hospital – repository for patched gloves, bent Kelly clamps, needles with fish hooks on the end, and the anesthesia equipment that is too good to throw away and too outmoded to use in the operating room.

FOR the unionized hospital, the building of good morale is an important function of both general administrative people and personnel administrators, and union leaders approve the effort. For the nonunionized hospital, the current union drive illustrates the pressures that administrators are under to put their house in order themselves without force from the outside.

THE inclusion of representatives of the medical staff on the hospital planning team not only will bring out fresh ideas, but will improve the doctors' understanding of the physical and financial limitations on hospital construction.

ONE would be a fool to suggest that every hospital have a director of public relations whose sole job was to direct public relations. But he would be equally foolish if he failed to advocate that each hospital have an ongoing public relations program.

IT HAS now become a little old-fashioned to assume that every patient who enters a hospital must be bedridden and waited on hand and foot.

THE first year of a new hospital's operation places excessive demands upon department heads. Therefore, their selection is the single most important task of the administrator in the year preceding the opening.

THERE is quite an art to simple yet complete reporting to the board of trustees. Some trustees sit diligently through meeting after meeting with explanation after explanation by the administrator, yet absorb absolutely nothing regarding the facts of hospital operation. The administrator must become a master in the presentation of facts and figures along with charts and statistics in order to make a total presentation understandable and meaningful.

ONE need not be hit over the head by a criticism or feel the elation of a compliment to understand that public relations is *now, today*—not something we had in the past or hope to have sometime in the future.

MAYBE we shouldn't worry so much about tomorrow's hospital. It is more to the point to get the right hospital today – by studying all the problems and providing creative solutions.

PAYING the architect on the basis of a percentage of total construction costs is archaic, unwieldy and impractical. And it offers a temptation for the architect to be careless in his figuring since his percentage rises with the costs.

Three Plus One Equals Three at Tri-State Hospital Assembly

The Tri-State Hospital Assembly, which represents four states, owes its inaccurate title to tradition rather than poor arithmetic. Here's how it happened. The original three states—Illinois, Indiana, Wisconsin—kept the title Tri-State Assembly even after the fourth state, Michigan, was admitted as a co-sponsor in 1940.

"Tri-State had become such a fixed expression in the minds of hospital personnel," said Leo Lyons, assembly program director, "that it was decided not to change the name of the organization."

Shown at right is Dr. Russell A. Nelson, A.H.A. president-elect, addressing opening session. Below: Sister Ernestine Mersek (left) and Sister Grace Marie of St. Margaret's Hospital, Spring Valley, Ill.

(Continued From Page 74)

1. Prompt and accurate patient billings, providing improved control of revenues.
2. Rapid, accurate and complete reporting of accounts receivable, reducing losses on receivables to less than one-half of 1 per cent.
3. Provision of a complete "activity register" on all open accounts.
4. Monthly "aged" trial balance of receivables.
5. Improved, rapid payroll operation.
6. Improved inventory control, including periodic "stock status" reports.
7. Complete medical record index reports.
8. Greater flexibility in all accounting and statistical operations.

Hospitals do an inadequate job of screening medical admissions, Dr. Robert Mustell of Chicago, chairman of the Chicago Medical Society's emergency medical service, charged at one of the general assembly meetings. Many patients are admitted to hospitals who could be cared for adequately in their homes or in doctors' offices, Dr. Mustell said. Especially, he declared, patients admitted for diagnostic work-ups could often be spared the expense of hospitalization, since these services could be rendered by physicians using their own laboratory facilities.

Dr. Mustell's opinion was challenged by George Bugbee, president of the Health Information Foundation, New York, who said more accurate information is needed to substantiate the charge that hospital facilities and services are "overused."

Dr. Mustell described the emergency medical service through which the Chicago Medical Society has provided physicians from a panel of its members in 43,000 cases. He urged organization of similar medical services in other communities as a means of reducing unnecessary demand on hospital services.

Replying to a question from the audience, Mr. Bugbee described "progressive patient care" as a valuable experiment that should be continued. However, he added, the experiment to date has not produced evidence demonstrating that economies can be effected through progressive patient care.

"Thus I would urge hospitals not to invest large sums in facilities planned for progressive patient care and not adaptable to conventional services," he concluded.

At another session, Dr. Aims C. McGuinness urged progressive patient care on hospitals as a method of tailoring hospital services to individual patient needs. Under the present system hospitals categorize medical services, Dr. McGuinness said. "The approach should be instead: 'What do the people, as individuals, need?' " he stated.

Discussing progressive patient care, a conference of hospital administration students examined all aspects of the plan and concluded it offers many possibilities for improved patient care, if not savings in hospital operations. Actually, progressive patient care is not a new concept, Charles A. Markel, Northwestern University student, told the conference. A similar approach to the organization of hospital services prompted the introduction of group nursing in hospitals during World War I, and other elements of the concept appeared even earlier, he pointed out.

(For additional stories and pictures on the regional meetings, see pages 176, 178, 184 and 186.)

The plan puts supplies where the patients are

EVERY patient who is sick enough to enter a hospital is sick enough to want, and need, attentive personal nursing care. This theory underlies the design of Holy Cross Hospital, now under construction in San Fernando, Calif., where every room will be private and, in effect, an intensive nursing unit when and if the patient's

Architect's rendering of Holy Cross Hospital, now under construction in San Fernando, Calif. See also color reproduction of rendering on this month's cover.

THE AUTOMAT PLAN SAVES MONEY BY SAVING LABOR

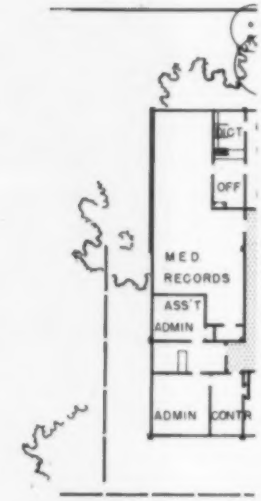
condition requires it. The theory that all patients deserve attentive personal nursing care is one with which few administrators would quarrel – at least out loud. "So who's arguing?" is likely to be the reaction when someone advances it. "But we've got to face facts. The nursing shortage, remember? And labor costs! And what do you think it would cost to build a hospital like that?"

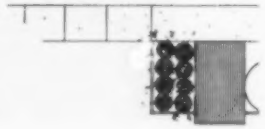
What the Sisters of the Holy Cross, Gordon Friesen, the hospital consultant, and Architects Verge and Clatworthy* think is that such a hospital will cost no more to build than a traditional structure – and that the cost of operating it will be lower in the long run because they will use machines and equipment to save the most valuable commodity of all – nursing time. They also think that private rooms will afford the patients protection from the hazards of cross-infection.

The design and equipment of the Holy Cross Hospital is a logical extension of the "Automat" system worked out by Mr. Friesen first at the United Mine Workers hospitals and later at the Berwick Hospital, Berwick, Pa.** Clean prepackaged supplies are brought to a central point to which nurses, and other employes, can come and be sure of finding all the supplies and materials they need without loss of time or steps. Like the Mine Workers and Berwick hospitals, Holy Cross will have a master dispatching and processing center on the ground floor (see plan) and smaller supply cores on each floor. But something new has been added, in fact, several somethings.

First is a double pass-through cabinet for each patient's room, built on the principle of a hotel "servidor" into which all linens and supplies required to care for the patient can be placed from the corridor side and removed, as they are needed, from the room side. This cabinet, which is divided into clean and dirty sections, opens into a small, enclosed area which houses a toilet,

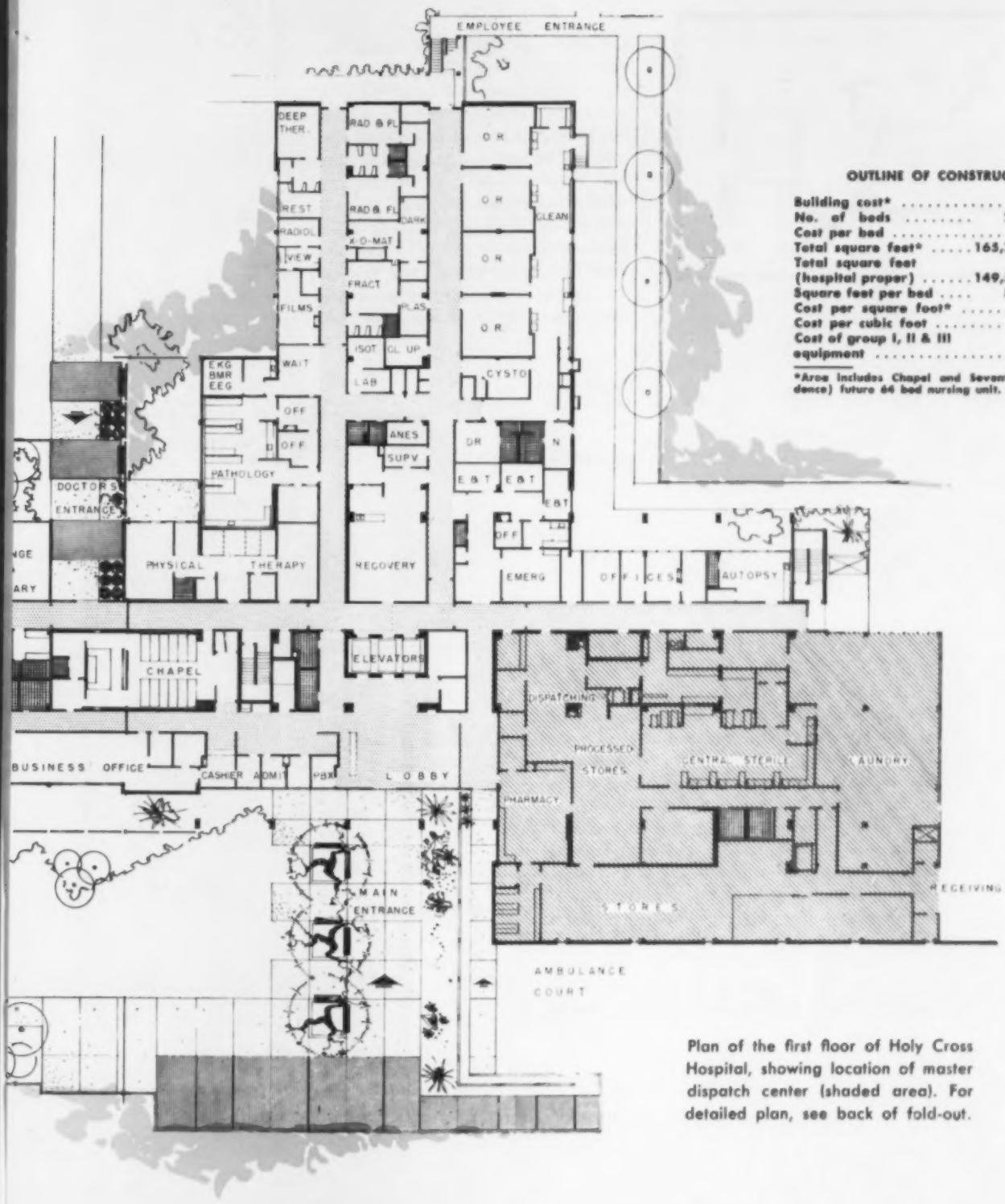
(*Text Continued on Fold-Out Page Opposite*)





*Holy Cross Hospital, San Fernando, Calif., is being built by the Sisters of the Holy Cross, Notre Dame, Ind. Consultant for the project is Gordon Friesen and Associates, Washington, D.C.; architects are Gene Verge & R. N. Clatworthy, Architects & Associates, Los Angeles, Calif. Plans and technical information for this article were supplied by Sister Mary Gerald, general treasurer of the Sisters of the Holy Cross, the consultant and architects, and by the Lamson Corporation, Syracuse, N.Y., American Sterilizer Company, Erie, Pa., and the Sonic Energy Laboratories of Bendix Aviation Corporation, Davenport, Iowa.

**See Automat Plan Puts All Supplies in One Place, The Modern Hospital, September 1957.



Plan of the first floor of Holy Cross Hospital, showing location of master dispatch center (shaded area). For detailed plan, see back of fold-out.

OUTLINE OF CONSTRUCTION COSTS

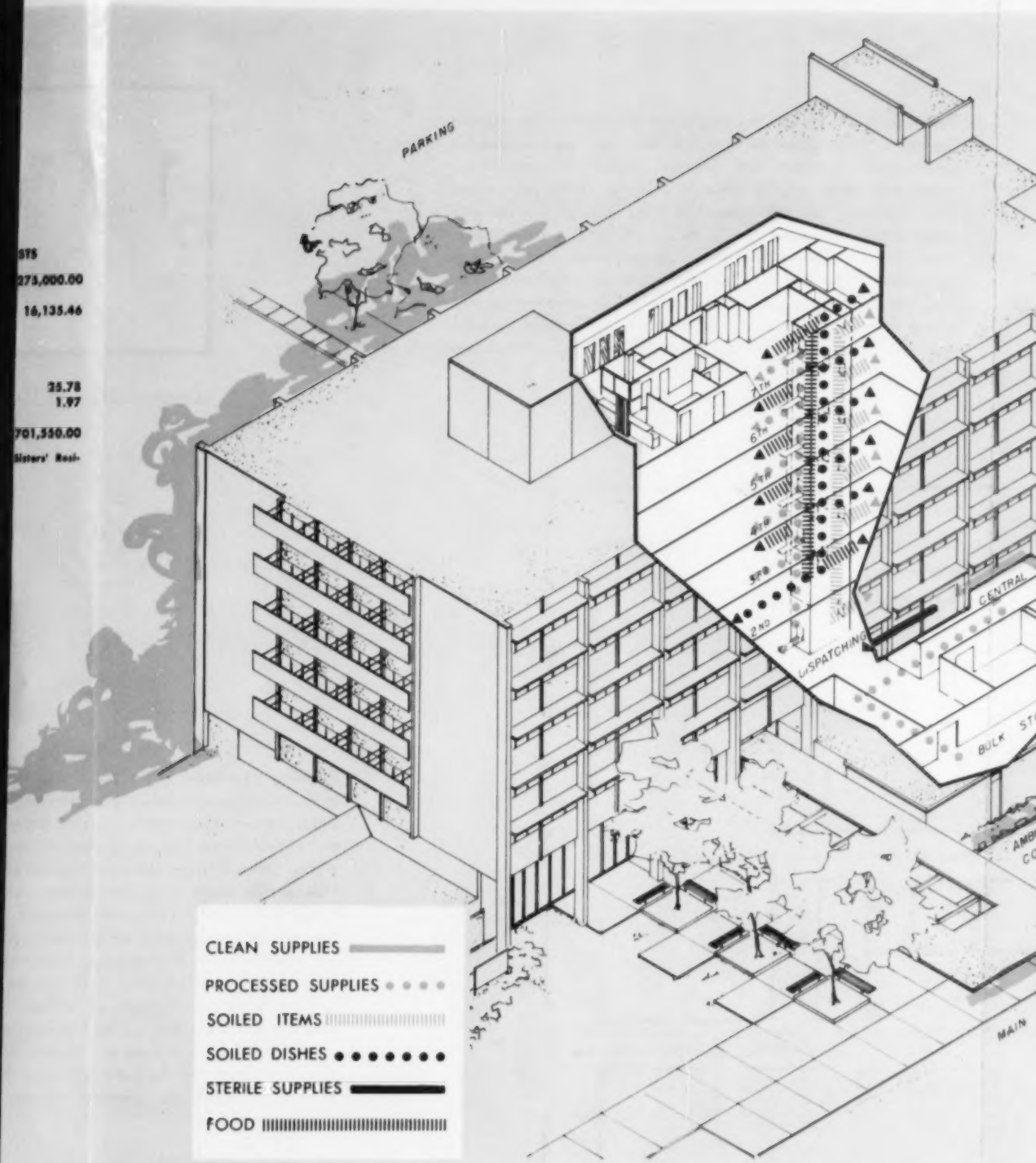
Building cost*	$4,273,000
No. of beds — 251	
Cost per bed	16,135
Total square feet* — 165,778	
Total square feet (hospital proper) — 149,539	
Square feet per bed — 596	
Cost per square foot*	25
Cost per cubic foot	1
Cost of group I, II & III equipment	701,550

*Area includes Chapel and Seventh Floor (Sisters' Residence) future 64 bed nursing unit.

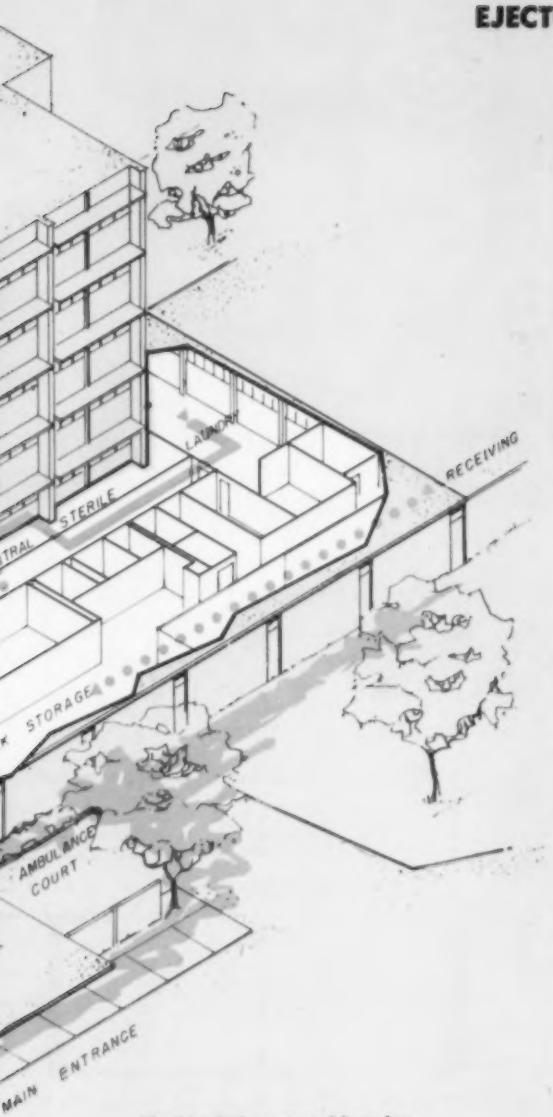
STS
275,000.00
16,135.46

25.78
1.97

701,550.00
Sisters' Resi-



EJECTOR SYSTEM SENDS TRAYS TO FLOORS



The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects, and the state agency. A similar award will be made each month.

(*Continued From Page* 78)

lavatory and shower as well as a utility section for the nurses. (See description by Sister Mary Gerald on page 85.)

Installation of the cabinets represents the achievement of Mr. Friesen's long-cherished goal of putting supplies where the nurses are. It is his conviction that the nurse's place is at the patient's bedside and the way to keep her there is to give her what she needs where she needs it, so that her time is spent looking after the patient, not looking for supplies. At Holy Cross Hospital, it is explained, the nurse should be able to go from one patient to the next, giving care, without ever having to double back to the floor supply core. In the event that some needed item is missing from the room cabinet, the nurse will have only to press a button and call the floor dispatching center to deliver it. While she is waiting, she can get on with other aspects of the patient's care.

Distribution of supplies to the floors from the central dispatching center is still another refinement of Mr. Friesen's efforts to get materials to their destination with expenditure of the least energy by the fewest people. This will be achieved by an automatic ejector system incorporated into the tray conveyors, which will permit automatic unloading at any patient floor. (See isometric drawing at left.) The automatic ejector has a capacity of eight trays per minute, with a 40 pound load per tray. Supplies will be assembled on standard aluminum cafeteria-style trays, 16½ by 22½ inches. When the trays are ready to go to the floors, they will be loaded on the horizontal belt, the dispatcher will push the proper button, and then the conveyor will take over and deliver the trays to the selected floors where they will emerge on a storage con-

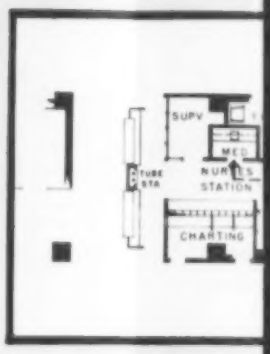
(*Continued on Page* 170)

MASTER DISPATCHING CENTER

CLEAN SUPPLIES
NEW SUPPLIES
PROCESSED SUPPLIES
SOILED ITEMS
SOILED DISHES
STERILE SUPPLIES
MEDICINE
UNPREPARED FOOD

CESSING SOILED EQUIPMENT HELPS REDUCE BACTERIAL COUNT AND PREVENT THE

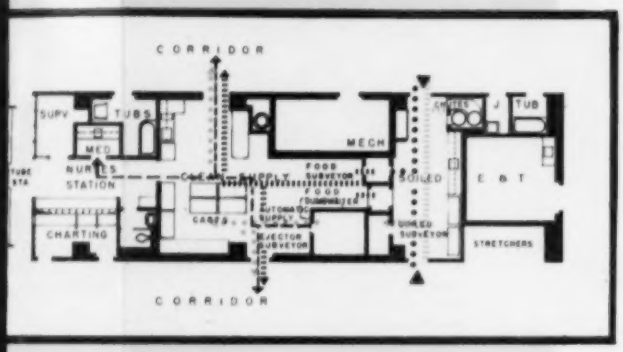
Below: Enlarged plan of the Holy Cross Hospital master dispatching center and related services, *i.e.* clean-up, decontamination, preparation, sterilizing and storage. Coded lines show how soiled and clean supplies move in and out of the department. Items that enter the soiled receiving area come on the conveyor which dispenses loaded trays automatically onto a roller topped table. Linen and dry goods go to laundry; waste and refuse go to the incinerator. The soiled-receiving area is a decontaminating area; all items coming in are sterilized in two double-door autoclaves after being cleaned and before entering clean preparation area. The technic is described in greater detail below.



SUPPLY CORE

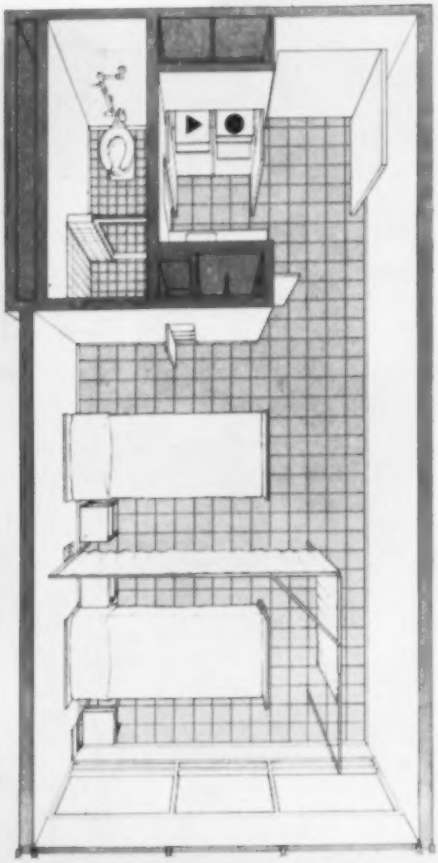
Cleaning equipment in the soiled area will
of a clinical hopper sink, a pair of manual
sinks, automatic mechanical utensil washer
matic mechanical laboratory glass washer,
cleaner, and a large combination action ul
cleaner that cleans equipment by sonic wav
bined with special germicidal detergent
The two sterilizers, both of the high-spee
are equipped with high pressure steam and
also equipped for ethylene oxide gas steril
Grossly soiled items, such as bedpans,
checked and gross soil removed by brush a
micide in the clinical hopper sink. Items th
precise cleaning will be thoroughly processe
ultrasonic cleaner. In ultrasonic cleaners,

...ENT THE SPREAD OF INFECTION



Left: Floor supply core on a typical patient floor, showing flow of clean and soiled supplies into and out of the area and relation of supply center to nurses' station and charting section. Clean supplies will be delivered to rooms at night and soiled supplies will be collected from rooms at intervals during the day and brought to soiled receiving area. Below: Drawing of patient's room indicates relation of patient's bed to "utility" section which includes toilet and shower and the clean-soiled cabinets.

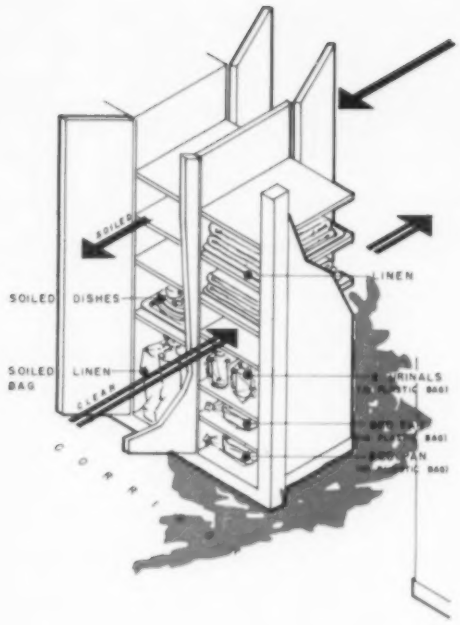
TYPICAL BEDROOM



...ed area will consist ...r of manual washing ...tensil washer, auto- ...lass washer, needle ...ion action ultrasonic ...by sonic waves com- ... detergent solution. ...e high-speed type, ...e steam and one is ...ide gas sterilization. ... bedpans, will be ...d by brush and ger- ...ink. Items that need ...ghly processed in the ...ic cleaners, sound waves of the proper type transmitted into a cleaning solution cause the solution to cavitate. Basically, this means that tremendous pressure differentials are set up. The energy released as these pressures move toward equilibrium literally tears soil from items immersed in the activated liquid. Combination of sonic energy with a germicidal solution will significantly reduce the bacterial count. In a sonically activated bath, energy imparted through cavitation removes and disperses the soils which normally mask the microorganisms. The bacterial clumps are broken up by the sound wave, thus exposing each bacterium to the germicide as a separate entity. Mixing action induced by sonic energy at locus of each microorganism lowers concentration of waste products.

DISTRIBUTION SYSTEM SAVES "RUNNING" TIME

Sister Mary Gerald



ISOMETRIC DRAWING OF PASS-THROUGH CABINETS

HOLY CROSS HOSPITAL, which is being built in the northern San Fernando Valley, will be owned and operated by the Sisters of the Holy Cross from Notre Dame, Ind. The hospital will provide a revolutionary system of supply that is estimated to save about 30 per cent of the nurses' valuable time.

The basic principle of time-saving for doctors and nurses is the placing of all supplies on a production-line system. Everything will emanate from a central area on the ground floor. This area will include central sterile supply, pharmacy, general stores, purchasing, linen and laundry and will have direct access to all departments. Supplies will be sent from a central dispatching area to various nursing units by means of an ejector belt similar to the type used in industry. This belt will deposit goods at a central supply core at each nurses' station even though the nurse may not be at the core to receive the goods. This will be a considerable improvement over the dumb-waiter system which requires that the nurse wait at the dumb-waiter for items ordered.

Countless hours of valuable time are lost in hospitals because nurses, aides and orderlies must obtain essential supplies from dozens of sources, generally remote from the surgery, delivery room, or patients' rooms. Transporting supplies in busy corridors and elevators by day results in confusion and waste of time. In Holy Cross Hospital much of this work will be handled at night.

Each patient's room will have an enclosed area immediately inside the entrance. This area will contain a wash basin, toilet and a built-in, counter-size cupboard (see cut at left). This cupboard, built in two sections, will be accessible from the patient's room and from the corridor. This makes it possible for the night force to deposit supplies needed for morning nursing care without entering the patient's room. The second section, also accessible from the corridor, is equipped with shelves for used supplies and a hamper section for soiled linen. Later, maids collect soiled linen and deposit it in the chutes available on each floor. These chutes open directly into the laundry.

Each patient's room will be equipped with a private shower. Early ambulation has decreased the need for bed baths and increased the need for shower facilities. The private shower enables the nurse to make the bed while the patient bathes, keeps her within calling dis-

Sister Mary Gerald is general treasurer of the Sisters of the Holy Cross, Notre Dame, Ind.

tance, and eliminates the need to walk with the patient to and from a general bathroom. Since nursing service is the largest segment of expense in the hospital's budget, the cost of individual showers will be amortized in a short time through the saving of nursing time.

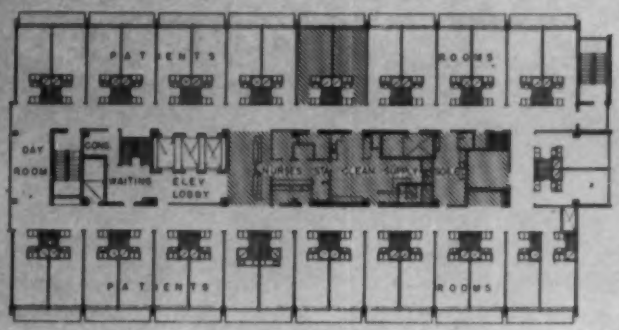
The hospital will be equipped with a pneumatic tube system. A tray conveyor will transport food. All patients' rooms will provide an excellent view of the towering mountains of the San Fernando Valley.

The entrance to the emergency department will be next to the main entrance. This location will enable the night attendant at the main lobby to see that emergency cases receive immediate attention. The emergency department adjoins the recovery room and surgery and provides for expansion into these areas in the event of an accident involving a large number of persons.

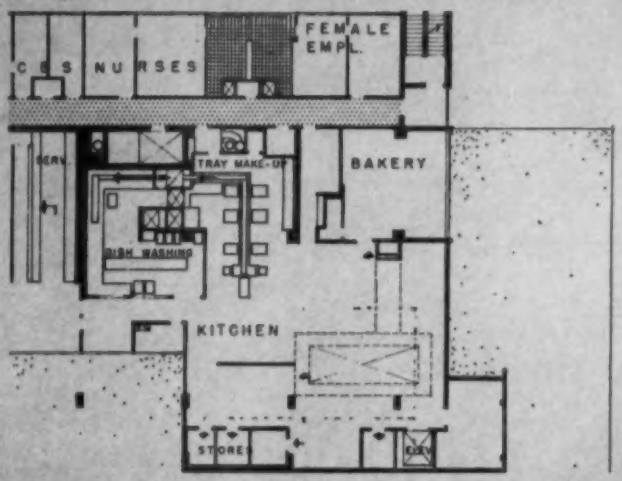
The chapel, located immediately off the lobby, will be convenient for patients, personnel and visitors. It will be soundproof.

The Sisters of the Holy Cross are dedicated to care for the physical, mental, social, spiritual and financial needs of their patients. Their dedication recognizes the moral obligation to discharge with economy and efficiency the responsibility of spending the millions entrusted to them for the care of the sick to whom they are privileged to minister. ■

Cost of Individual Showers Will Be Amortized Quickly Through the Saving of Nursing Time



Plan of typical nursing floor shows central location of floor service core in relation to patient rooms. Patient rooms are provided with their own toilet, lavatory and shower facilities.



Plan of the food service department on the second floor. Food will be sent up from the kitchen on regular tray conveyors, supplemented by dumb-waiters when they are needed.

Capacity class of 57 attends Emerson Hospital refresher course for nurses twice a week. Here, the class members learn how new circular bed operates.

Edmund J. McTernan

Refresher course earns its place on the budget

A REFRESHER course for professional nurses, opened at Emerson Hospital, Concord, Mass., in March, has, in the opinion of the administration, earned itself a place as one of the most worth-while items on the nursing budget.

The course had a threefold purpose. First, the course offered an opportunity for nurses who served in the hospital, either full time or part time, to learn new technics in a formal teaching situation. This was believed to be particularly valuable to the nurse who restricted herself to occasional special duty nursing. Second, there were many nurses in the community who had been inactive for some time who would feel more confident about returning to nursing if they had an opportunity to be brought up to date. It was believed that this would increase the pool of available nurses in the community, for both regular and emergency service in the hospital. Finally, the hospital enjoys a reputation of being a modern and progressive institution, dedicated primarily to the needs of the community. The service and public relations value of the proposed course were believed to be considerable.

Emerson, an 85 bed general community hospital, is not primarily intended for teaching. However, it has been the philosophy of the administration that the presence of students increases the caliber of the care given. Affiliations have been arranged with a school of practical nursing for the training of student practical nurses, and with a junior college program for the clinical training of two-year professional nurses. In addition, regular formal training is offered to auxiliary nursing personnel, and a strong in-service program for all levels of nursing personnel is being developed.

To meet the needs occasioned by these programs, a division of nursing

Edmund J. McTernan is assistant administrator, Emerson Hospital, Concord, Mass.

education has been established within the nursing department. The staff of this division consists of one supervisor and two part-time instructors — all registered nurses. Planning the new refresher course became the joint task of this supervisor and the assistant administrator in charge of nursing.

General policies for the establishment of the course were developed to meet our particular needs; they might vary greatly under other circumstances. These policies were:

1. The course would be open only to graduate professional nurses, but registration in the state was *not* required.

2. There would be no charge for attendance, nor would the nurse incur any obligation to the hospital in return for her participation.

3. The supervisor of nursing education would act as coordinator for the course; however, most lectures would be given by specialists in the area under study.

4. No limitations would be placed on the nurse's age, year of graduation, or when she was last employed in nursing, nor upon geographic location of residence.

5. Teaching would be by lecture and demonstration.

After the formulation of general policies, the next step was to set up the curriculum. To determine the topics most necessary, we compared present nursing school curriculums with those of some years ago; conferred with nurses to determine what they felt were important developments of the last several years, and searched the literature. Of unique value were the statements of some staff nurses who had returned to nursing recently after prolonged absences.

The material to be covered was then discussed with various local authorities in the medical, nursing and pharmaceutical fields, and the time to be devoted to each area was determined. It was felt that 40 hours would be adequate for the content of the original curriculum; since then, additional topics have been added, but it was possible to include them without increasing the total number of class hours. Original plans called for two separate sections of the course, *i.e.* a morning group and an evening group. This plan had to be abandoned because of the limited free time of several volunteer faculty members, and only the evening session was offered. It was the consensus that two-hour sessions, each consisting of two 55 minute periods with a 10 minute break between them, were most practical. Local conditions dictated the choice of the hours of 7:30 to 9:30 p.m.

A faculty of 29 persons was then assembled, 24 of them volunteers who agreed to give one or two hour lectures on special subjects as a contribution to the hospital and the community. Of the 24, six are physicians from the hospital staff: a surgeon, an internist, an anesthesiologist, an orthopedist, a psychiatrist and a neurosurgeon. Two are nurse-instructors from the school of nursing of another hospital.

One is an inhalation therapy consultant from a chemical company. Three are representatives of medical equipment manufacturers. One is a public health nurse from the hospital's service area. Five are representatives of ethical drug manufacturers. The remaining eight are all on the hospital staff, as follows: the operating room supervisor, the chief x-ray technician, the chief laboratory technician, the pharmacist, the dietitian, the physical therapist, the obstetrical supervisor, and an assistant administrator. The three paid faculty members were the three members of the nursing education staff. All hospital employes except the nursing education group served without pay on their off-duty time.

Announcement of the course was made through two releases to weekly newspapers in the surrounding communities, two weeks apart, and beginning about six weeks before the opening date of the course. It was anticipated that 12 to 20 persons would apply, and that publicity releases would go out approximately four times before the course began. Within four weeks, 55 applicants had registered — the maximum number possible be-

Community hospital finds

Ruth A. Powers, R.N.

Curriculum for South Nassau Course

Monday	**9-10 a.m.**	**Medical lecture on cardiac illnesses, such as coronary, hypertensive heart disease, and so on.**
	10-11 a.m.	**Ward practice (experience with cases discussed).**
	11-12 noon	**Nursing in cardiac illnesses, including O_2 therapy demonstration.**
Wednesday	**9-10 a.m.**	**Chest surgery lecture (pathological and anatomical aspects) first of two lectures.**
	10-11 a.m.	**Ward practice.**
	11-12 noon	**Film "Open Heart Surgery."**
Friday	**9-10 a.m.**	**Nursing care of chest surgical cases with demonstration of underwater drainage, and so forth.**
	10-12 noon	**Ward practice "intensive care."**

There are 20 hours of planned doctors' lectures, in addition to the showing of related films and filmstrips; 20 hours of nursing classes; 14 hours of ward practice, correlating the nursing and medical lectures; demonstrations by various drug and surgical supply companies, *i.e.* the portable lifter demonstration in conjunction with rehabilitation nursing.

cause of space limitations. An additional 15 had to be refused registration after the roster was filled to capacity. Further publicity designed to attract applicants was suspended. Of the 55 enrolled, 33 have been inactive. Several of these do not anticipate return to nursing except in emergencies; but several have indicated a willingness to do part-time work. Ten are employed in other hospitals. They represent 35 schools of nursing in seven different states, and graduation classes from 1914 to 1951. Attendance was good, with an average attendance of 50. Individual lectures were open to staff nurses not registered in the course as space permitted.

Of the three purposes for which the course was offered, all have been met, at least in part. Nurses are enthusiastic about the new technics they have learned. Several older women have stated that they would now feel confident in returning to duty. The hospital has received word from approximately a half-dozen, to date, who would be willing to do part-time duty, although they are not needed at the present time. In an emergency, the class roster would provide us with an appreciable reserve to call on for temporary assistance. ■

Emerson's Refresher Course for Nurses

Subjects covered in the final curriculum, and the time devoted to each, are as follows: orientation; new trends in laboratory procedures; anesthesia and intravenous therapy; operating room, central supply, and recovery room; burns and trauma; nursing care of the burned patient; fractures and bone trauma; x-ray; physical therapy; catheterization; obstetrics and newborn care; neurology; nursing care of neurological patients; oxygen and inhalation therapy; medication procedures; public health; diet therapy, psychology of the patient; infections, precaution technic, and reversed precautions; new patterns in patient care — all one-hour lectures; new equipment — two hours; tracheostomy, Harrison, and Levine tubes — two hours; pharmacology — 12 hours; electrolytes and steroids — two hours; round table summary — two hours.

way to maintain a reservoir of nurses

TODAY, with so many hospitals in great need of registered professional nurses, one of Long Island's community hospitals has found a sure method of maintaining a standby supply of the much needed R. N.'s.

In May 1955, at the conclusion of the expansion program that increased its capacity from 98 to 230 beds, South Nassau Communities Hospital, Oceanside, N.Y., was faced with a pressing need for R.N.'s to staff the new wings.

In surveying the problems, the director of nurses hit upon an idea which has proved to be most successful in solving the R.N. shortage — a refresher course for nurses who have been inactive for a considerable period of time.

As soon as the program was set up, an invitation was extended via the press and over local radio stations to the more than 2000 inactive nurses living in the county to register for the course.

The response was overwhelming. Interviews at registration revealed that many registrants had wanted to resume their careers but did not know just what was the best method of learning new devices and technics; many had left hospital nursing for other specialty fields and others, after years of inactivity, felt insecure and hesitant. For some of them it meant resuming nursing after 20 years of retirement!

Fulfilled Real Need

The first course was a great success, for it fulfilled a real need on the part of the nurses, as well as the hospital.

Two refresher courses for nurses have been conducted yearly since 1955 at South Nassau, with revisions and additions made as it became necessary. At the beginning of the course each nurse receives an evaluation sheet, which she submits to the instructor at the completion of the course. The evaluations are reviewed and, if necessary, the instructor revises the program.

With every interest directed toward bringing the inactive nurse up to date rapidly, the program has been planned to present no interference with home situations. Since the majority of nurses have children on full-time or part-time school schedules, it was found that 9 a.m. to 12 noon is the most convenient time for all — doctors, nurses and hospital staff. The course is conducted on Monday, Wednesday and Friday for a six-week period, under the direction of the in-staff education supervisor. It has been found that a gradual introduction to a refresher nurse program as opposed to a shorter intensive daily program provides better adjustment, greater understanding and acceptance of modern technics.

Prior to registration the nurses come to the hospital for an interview, file an application, and are thoroughly informed of the program and the motives for maintaining such a community service. Since the program does not require any fee, the nurses are asked to donate two eight-hour days at the completion of the course for additional hospital practice and experience. The hours and time are ar-

Ruth A. Powers, R.N., is in-staff education supervisor, South Nassau Communities Hospital, Oceanside, N.Y.

ranged at the convenience of the participating nurse.

The eighth refresher course at South Nassau Communities Hospital commenced in April of this year. The course content consists of a review of basic nursing procedures: oxygen therapy, gastrointestinal decompression, sengstaccken tube tamponade, catheterization, maternal and infant care, drug therapy, thoracic and cardiac surgery (intensive care units), care of urological patients, care of fractures, traction, hipnailing (orthopedic), thermatic thoracic chest pump, care of tracheotomy patients, care of colostomies, nutrition in disease, care of craniotomies, recovery room technics, and teaching the diabetic.

The course content covers many phases of patient care – obstetrical, nursery, pediatric, medical and surgical nursing, recovery room and intensive care, rehabilitation and disaster nursing.

The one-week schedule shown in the box on page 88 is submitted to give a clearer interpretation of the program. (Each hospital would, of course, plan the schedule to suit its own particular need and time allotted for the program, taking into consideration the background of the nurses who register for the course.)

The refresher nurses receive clinical and practical experience by rotation method, similar to student nurse assignment. The recovery room and intensive care unit offer extensive practical experience so that all of the nurses spend an eight-hour day on each service in addition to whatever the rotating schedule may offer them. The inservice supervisor has some assistance from the head nurses in carrying out follow-up on case load and practical experience.

All Groups Enthusiastic

The groups have been enthusiastic about the program. All nurses have indicated that they would not have returned to nursing if they had not first of all been attracted by the refresher course, and second, received the guidance and assurance that they derived from the course.

By conducting a refresher-type nurses' educational program twice a year, it has been possible to meet the nurse shortage of staff personnel caused by resignations, vacations, marriages and pregnancies. Many of the refresher nurses have accepted responsible staff positions, working into assistant charge nurse, recovery room staff nurse, emergency room nurse, nursery nurse, and charge nurse relief. Many are employed on a part-time basis as per diem servicing – doing one, two or three days, as the home situation permits. Of the last class of 14, 12 are actively working on the hospital staff.

A very small percentage of the "graduates" have remained inactive following completion of the program.

Of the 73 nurses who have taken the course since 1955, 46 currently are employed on the staff or on a per diem basis. ■

Members of a refresher class for nurses at South Nassau Communities Hospital gather in the auditorium to watch a film on open heart surgery.

Below: Mrs. Powers supervises refresher nurse as she administers suction to patient in intensive care unit.

Below: Two nurses in recovery room are instructed by Mrs. Powers in procedure for taking vital signs.

When Nurses Are Negligent, They Are Liable

In this review of cases brought before the California courts, it is pointed out that no nurse is free from liability for negligence and wrongdoing when she should have foreseen that damage would result from her actions

Albert Woodruff Gray

DEFINITIONS are at best uncertain and evasive. "No one means all he says and yet very few say all they mean, for words are slippery," was the comment of Henry Adams. Long ago the definition was made by the Michigan supreme court that, "Negligence consists in the failure to observe that degree of care which the law requires for the protection of the interests likely to be injuriously affected by the want of it."

While the statement suggests the youngster's definition that salt is what makes potatoes taste bad when it isn't put on, the comment was nevertheless made by that court that this definition was made by one of the ablest legal writers of modern times.

While a hospital may or may not be responsible for the negligence of a nurse in its employ, no nurse is free of liability for negligence and wrongdoing merely because she was employed by the hospital.

Upon every nurse, as upon other workers, the law imposes the duty to use "due care and proper precaution" that she does not negligently injure others. In other words, responsibility on the part of a nurse is established by proof that she ought to have known or foreseen that injury or damage would be the result of her conduct.[1]

At a hospital in Southern California a boy underwent an operation for hernia. Except for this condition he had been in good health. For eight days after the operation his condition remained normal when suddenly his temperature reached 101° F. and a pleuritic pain in his right side elicited the diagnosis of broncho-pneumonia.

During the next two days his fever registered 102.6° F. and the patient was flushed and dyspneic. At noon on the second day he told the resident physician that he was suffering from a tight feeling in his throat and a pain when he attempted to open his mouth.

This doctor told the supervisor of nurses that to him it looked "like this might be a case of tetanus," and directed her to call the attending physician. That afternoon the nurse's chart showed that the patient had undergone progressive deterioration, pain and stiffness in his neck, tightness in his chest, and difficulty in opening his mouth and swallowing.

Early in the evening the mother of the patient called at the hospital and was alarmed at the marked change for the worse. Calling the head nurse she remonstrated with her for three hours only to be told that the operating surgeon would not arrive at the hospital until 11 p.m.. However, between two and three hours later another physician, who happened to be at the hospital, was summoned by the night supervisor.

His examination of the boy verified the earlier suggestion made by the resident physician more than 10 hours before, that the patient was suffering from tetanus, and he directed that he be immediately removed to the county hospital. Shortly before 2 o'clock that morning the patient arrived at that hospital and died the following day.

In its characterization of the conduct of the nurse in failing to accord this patient the care and skill which the law requires, the appellate court said, "Malpractice is the neglect of a physician or nurse to apply that degree of skill and learning in treating a patient that is customarily applied in treating and caring for the sick or wounded similarly suffering in the same community.

"While the law makes allowances for human weakness in the application of skill and learning, the facts of each case must be judged according to their own merits." To this general statement the court added its conclusion in relation to these particular facts:

"Viewing the facts of this case it is inescapable that in the treatment and nursing of the patient the servants of the hospital were negligent in failing to exercise ordinary care in two respects, namely,

"(1) In the application of the skill, learning and diligence reasonably required in a private hospital in Los Angeles at that time and,

"(2) In refusing to take steps for the protection of the patient or to act, when evidence of the pathological condition and of the progressive deterioration was brought to their attention."

Of the negligence in these circumstances the court continued, "It is es-

(Continued on Page 172)

Mr. Gray is an attorney, New York.

[1] 35 Am. Jurisprudence 1024

A.H.A. on outside looking in

National League for Nursing Votes for Exclusive Control of Accreditation Policy

PHILADELPHIA. — The National League for Nursing has drawn a circle around its program of nursing accreditation and shut out the American Hospital Association.

During a special two-day session preceding the group's national meeting here last month, the N.L.N.'s council of member agencies voted overwhelmingly to approve a statement that deletes all reference to A.H.A. participation in and responsibility for policy making activities concerning accreditation.

The approved statement, "The Present Thinking of the N.L.N. Board of Directors on Accreditation Policy," makes its point in the first sentence: "The N.L.N. board of directors reaffirms its basic position that responsibility for the establishment of standards and improvement of nursing education rests with the N.L.N."

Although the statement is designed to keep policy setting within the N.L.N., it does provide for an advisory committee through which A.H.A. representatives could work with the League on accreditation matters.

In effect, the League seemed to be telling the A.H.A., "You can advise us, but we'll make the decisions."

The size of the majority for the statement — of 866 votes cast, 783 were for the statement — indicated that the assurances of the A.H.A. spokesman, Dr. Stewart Hamilton, while effective, were not enough. Dr. Hamilton, director of Hartford Hospital, Hartford, Conn., spoke before the vote was taken. He suggested that inclusion of the A.H.A. on accreditation matters would not lower the standards of nursing education, but that the accreditation program would be stronger if the two organizations shared the responsibility and worked together.

At the end of the meeting it was clear that although the League may encourage joint thinking as a harmless social pastime, it is not ready to turn over or share its policy making responsibilities with another association, A.H.A. cajolery notwithstanding.

Nursing accreditation has been a major topic of discussion between the A.H.A. and N.L.N. since the A.H.A. house of delegates proposed last August that "an independent joint commission to accredit hospital schools of nursing be established by the A.H.A., A.M.A., and N.L.N. as rapidly as feasible."

This action caused anguish and some turmoil and galvanized the N.L.N. to action.

Following official notification of A.H.A.'s intent to form an independent commission on accreditation, members of N.L.N. steering committee of the department of diploma and associate degree programs met to study the resolution and the various reactions to it. They then formulated and forwarded to the N.L.N. board of directors several recommendations including one that stated "the accreditation of all educational programs in nursing should remain the responsibility of the League." This and the other recommendations were endorsed by the steering committee of the department of baccalaureate and higher degree programs, and the subcommittee of practical nurse education, the other two educational units in the N.L.N. Division of Nursing Education.

In November 1958 the N.L.N. board passed the following resolution and forwarded it to the A.H.A.:

"*Whereas*, the N.L.N. board of directors is of the opinion that professional accreditation of schools of nursing belongs to the body set up for the express purpose of improving nursing education and evaluating nursing services, and

"*Whereas*, the N.L.N. board of directors is of the opinion that the accreditation of hospital schools of nursing has produced desirable results and has demonstrated the attainability of accreditation for hospital schools of nursing, and

"*Whereas*, the board of directors of N.L.N. has directed that A.H.A. be so advised,

Be it resolved that the N.L.N. board of directors reaffirm its conviction of the role N.L.N. must continue to play in accreditation and that it convey this conviction to A.H.A. through conferences with A.H.A. representatives to examine all facets of the accreditation program."

This resolution was presented to the councils of member agencies and to the state leagues for nursing for opinions. A great majority of the respondents agreed that the N.L.N. should continue its role in the accreditation of hospital schools of nursing.

At this time, the N.L.N. board of directors arranged for representatives of the N.L.N. to meet with representatives of the A.H.A. to discuss the accreditation controversy. As a result of this meeting, the two boards approved a recommendation that two committees be created: an ad hoc committee to consider all aspects of accreditation and to make recommendations, and a joint committee of the boards of the N.L.N. and A.H.A. as a continuing committee that would be concerned with broad issues of mutual concern to both associations. By the end of April this year, both committees had met.

The joint committee of the two boards made the following recommendations:

1. Joint exploration of accreditation of hospital schools of nursing should be continued for the following purposes: (a) improving and simplifying procedure; (b) providing for stable financing.

2. Joint A.H.A.-N.L.N. responsibility for accreditation should be considered.

3. A policy committee should be formed within the N.L.N. on the accreditation of hospital schools of nursing consisting of 14 members, seven to be appointed by A.H.A. and seven to be appointed by N.L.N.:

a. To receive and approve reports from the board of review.

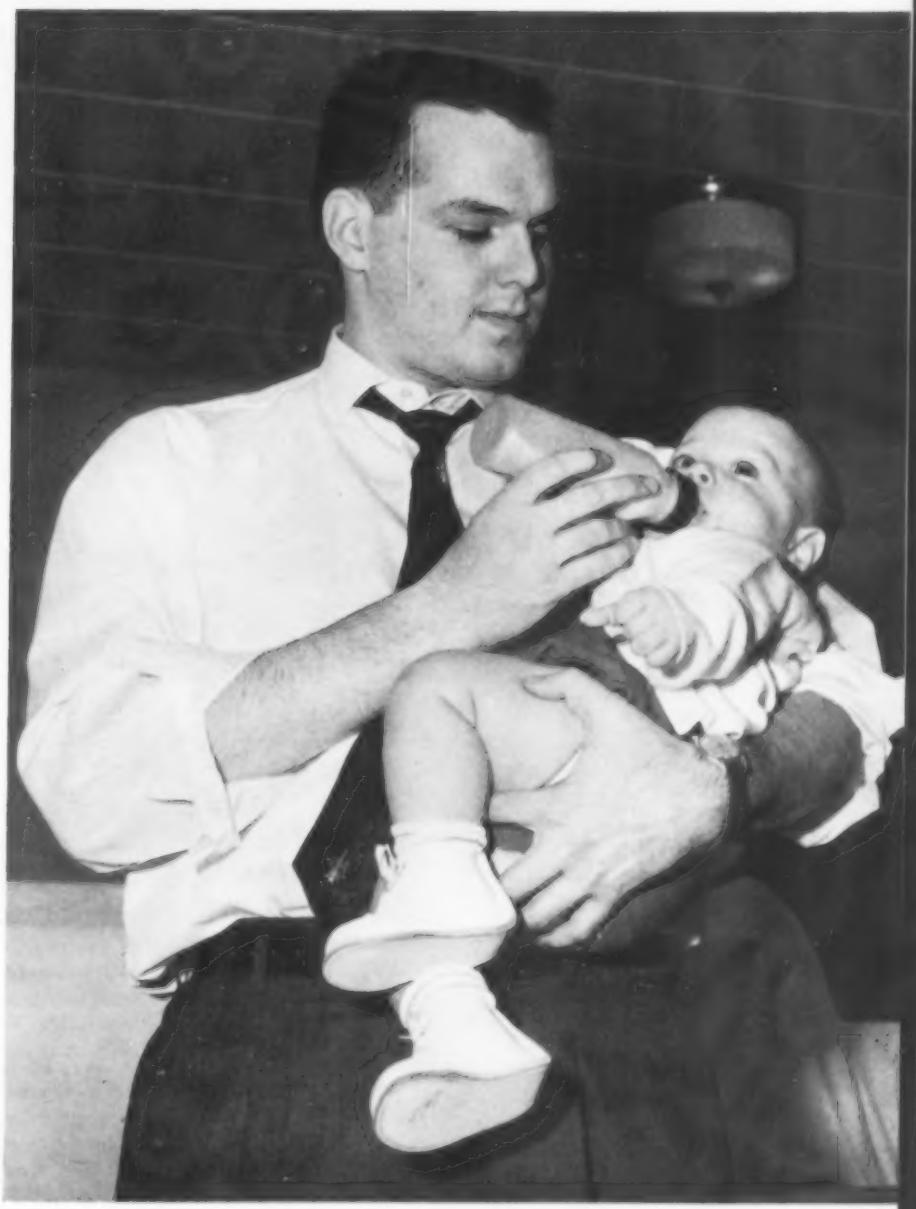
b. To consider problems and make recommendations on policy and procedure to the board of N.L.N.

c. To evaluate the accrediting program in relation to established objectives and policies. The members of this committee should also serve as an interorganization committee of the N.L.N. and A.H.A. to consider and recommend methods or procedures.

The N.L.N. board of directors considered these recommendations but in the words of League President Ruth Freeman, "The board believed it not appropriate to take action in this matter inasmuch as it was primarily the concern of the steering committee of the department of diploma and asso-

(*Continued on Page* 180)

Baby Is a Parent's Best Teacher



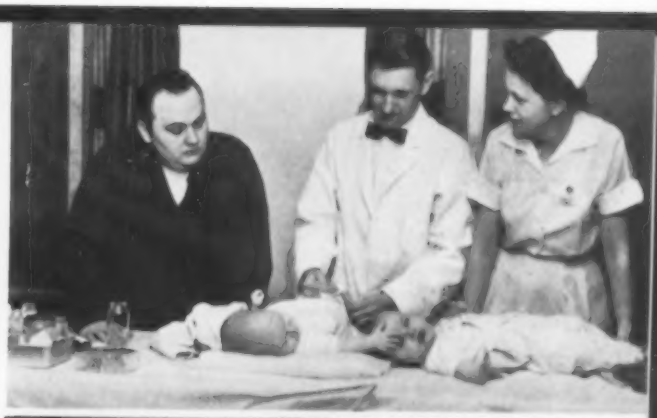
Baby Tom Riley, aided by his father, shows expectant fathers' class proper feeding method.

Live models are the main attraction each year for the expectant parents' classes at MacNeal Memorial Hospital, Berwyn, Ill. The babies shown on this and the following two pages give prospective parents a real-life demonstration of what to expect of their

(*Text Continued on Page* 95)

HOSPITAL'S COURSE FOR EXPECTANT PARENTS COVERS EVERYTHING — INCLUDING THE BABY

Above: Models for expectant mothers' class return to the hospital after one year to give a graphic live demonstration of growth rates. Center: Three babies give a live illustration of light, medium and heavy weights. Crowns worn by the babies indicate their weights at birth. Left: The entire group of 10 lines up for comparison, in wiggling as well as weight. Dr. Francis Kodl, pediatrician at MacNeal Hospital conducted this unique seminar on growth.



Above: One father demonstrates his changing technic on his 13 month old daughter. Above, right: For expectant father, doctor proves his virtuosity at diapering, in duplicate, on twins.

(*Continued From Page* 93)

own babies. MacNeal offers the course five times a year. Nearly 1600 women have attended the courses since 1949.

Each course consists of seven lectures for mothers and one for fathers. The first four sessions explain human reproduction and the stages of pregnancy.

The new baby steals the spotlight in the remaining classes, which cover everything from the proper method of holding and bathing the infant to the preparation of his formula.

The fathers' class meets at night. Experienced fathers bring their babies and demonstrate feeding, bathing and diaper changing technics. They also answer questions covering such things as burping theories and interpreting the baby's cry.

The last mothers' class studies the child's growth and development. This year 10 babies returned to show how they had grown in a year. Their mothers told the class the behavior and development problems they had encountered. ■

In three pictures at right Baby Riley helps his father with the demonstration and question period. "Please, not in front of all these people," he seems to say as his father shows them how to prepare for baby's bath under Mrs. Riley's supervision. Then he prepares to help present the panel discussion for expectant fathers, and, finally decides the only way to make his position clear is to take the microphone from Dr. Arthur Consing, the instructor.

1. UNIFORM CODING OF CERTAIN TISSUES

Code	
1	Appendix, acutely inflamed, tumor or granuloma
2	Appendix, fibrosis, pinworm, lymphoid hyperplasia, subacute
3	Appendix, nothing in muscularis or serosa
2	Cervicitis
3	D & C, normal endometrium
1	D & C, polyps
1	D & C, placental tissue
1	Endometriosis, active
2	Endometriosis, inactive or minute
2	Gallbladder, no stones, wall thin and elastic
1	Gallbladder, wall thick and inelastic
2	Gallbladder, cholesterosis
1	Gallbladder, stones present but wall thin
3	Gastric resection for duodenal ulcer
1	Gastric resection with ulcer present in specimen
2	Gastric resection with gastritis
2	Hemorrhoids
1	Hemorrhoids, thrombosed or inflamed
2	Hernia, general
1	Hernia, strangulation, tumor granuloma
2	Hernia, endometriosis, vas deferens, or other tissue
2	Ovaries, microcystic
3	Ovaries, corpus luteum
1	Ovaries, ruptured luteum cyst
3	Therapeutic abortion
2	T & A
1	T & A, specific infection, tumor or other pathology
3	Tubes or vas for sterilization
3	Uterus with normal pregnancy
2	Uterus, prolapse with keratosis of cervix
3	Uterus, hysterectomy for hemorrhage, if uterus looks normal
2	Uterus, fibroid, small and nonobstructing
1	Uterus, fibroid, obstructing or of sufficient magnitude to cause symptoms or trouble
2	Veins
1	Veins, with thrombosis or other pathology

2. CRITERIA FOR SELECTING CHARTS TO REFER TO TISSUE COMMITTEE*

OPERATIONS		REMARKS
Codes**	Description	
190-12	Simple mastectomy	Review all charts with tissue codes 2 and 3
640-12	Complete gastrectomy	Review all charts with tissue codes 2 and 3
640-13	Partial gastrectomy	
661-12	Appendectomy	Review all charts with tissue codes 2 and 3
687-12	Cholecystectomy	Review all charts with tissue codes 2 and 3
780-12		
788-12		
788-13	Operations on tubes	Review all charts with
788-122	and/or ovaries	tissue codes 2 and 3
787-12		
787-13		
782-10		
782-12		
782-12X	Operations on uterus	Review all charts with
782-13		tissue codes 2 and 3
782-14		
810-10		
810-12	Operations on thyroid	Review all charts with
810-13		tissue code 3

* Adapted from Tissue Committee Procedure, Butterworth Hospital, Grand Rapids, Mich.
** The codes in this column refer to those found in "Standard Nomenclature of Diseases and Operations.

How To Make

Vergil N. Slee, M.D.

THE hospital tissue committee has just one responsibility: to find out whether or not the surgery performed in the hospital was justified.[1] The goal of the tissue committee procedure should be to carry out the search for unjustified surgery with the minimum of waste motion and with maximum assurance that problem cases will be discovered. The committee works directly or indirectly from clinical records, going over them and applying a simple test of consistency. Basically, the committee asks the question: "Was the decision to perform this operation consistent with the symptoms, signs and other diagnostic findings presented?"

Roughly one-half of hospital surgical procedures result in the removal of tissue. For these the tissue committee has, in addition to preoperative data, the tissue findings in the pathologists' reports. Tissues are examined objectively in the laboratory, giving factual observations which are available as independent reference points. The pathology reports become the greatest single resource of the committee, a point which is recognized by naming the group "tissue committee" when it is really a "surgical justification committee."

For cases with tissue the committee

[1]Myers, Robert S.: Evaluation Proves Tissue Committee's Worth, Mod. Hosp. 92: 65 (April) 1959.

Dr. Slee is director of the Commission on Professional and Hospital Activities, Ann Arbor, Mich. The commission was established in 1955 by the American College of Physicians, the American College of Surgeons, the American Hospital Association, and the Southwestern Michigan Hospital Council to conduct research in the area of the improvement of hospital medical care. This article reports a development of the Professional Activity Study (P.A.S.), the major activity of the commission. The P.A.S. and also the medical audit program (a joint research project with the American College of Surgeons) are now available to hospitals throughout the United States.

the Tissue Committee's Work More Effective

has a time saving method available, since experience has demonstrated "the wisdom and practicability of accepting automatically certain tissue diagnoses as indication of justification for surgery."[2] If the findings in the pathology report amply justify the surgery, no further study of the case is made, since evaluation of preoperative care, surgical technic, and the like are not responsibilities of the tissue committee.

It is common practice for these tissue reports to be used by the committee in screening cases. For example, an appendix with acute inflammation, a uterus with a large fibromyoma, and a hernial sac with gangrenous bowel clearly were removed in operations which were justified. Clinical records with such pathology reports need not be studied further by the tissue committee since the tissue report automatically establishes the justification for surgery.

[2]Robert S. Myers, ibid.

Since 1954, hospitals participating in the Professional Activity Study (P.A.S.) of the Commission on Professional and Hospital Activities have utilized this principle. Coupled with the advanced data-presentation technics of the P.A.S., which show diagnosis, operation and tissue disease, as well as other information about each patient, the hospitals are able to streamline the tissue committee operation still further. The procedure works as follows: Pathologists serving the participating hospitals adopted a simple code for classifying the tissues examined into three categories:

1. Tissue disease generally requiring surgical removal.

2. Tissue diseased but surgical removal is not clearly required from the pathological findings alone.

3. No disease.

This code for the classification of tissues (shown in Illustration 1) was designed to ensure consistency of handling. For each tissue examined, the pathologist simply records the classification on the tissue report. The medical record librarian transfers this code onto the P.A.S. code sheet along with the diagnoses, operations and other data about the patient. If no tissue was removed, or no tissue report received, the record librarian codes this fact. Each month an operation listing is run for each hospital on a tabulating machine. Applying a set of rules agreed upon by the tissue committee, the medical record librarian simply dismisses certain cases as "justified" on the basis of the tissue finding. The clinical records that meet these criteria are not given to the committee and both the committee and the record librarian are relieved of much unnecessary handling and reading of charts. Illustration 2 shows some of the rules set up by one tissue committee to designate clinical records demanding individual review.

The result of applying this set of rules in five P.A.S. hospitals is shown

3. RESULTS OF APPLYING CRITERIA IN FIVE P.A.S. HOSPITALS

	HOSPITAL A			HOSPITAL B			HOSPITAL C			HOSPITAL D			HOSPITAL E		
		Justified by Tissue Disease			Justified by Tissue Disease			Justified by Tissue Disease			Justified by Tissue Disease			Justified by Tissue Disease	
OPERATIONS	Total	Number	Per Cent	Total	Number	Per Cent	Total	Number	Per Cent	Total	Number	Per Cent	Total	Number	Per Cent
Simple mastectomy	11	9	81.8	14	13	92.9	1	—	0.0	21	18	85.7	5	3	60.0
Gastrectomy	10	6	60.0	84	56	66.7	30	17	56.7	102	57	55.9	76	59	77.6
Appendectomy	82	58	70.7	172	146	84.9	123	90	73.2	376	245	65.2	76	57	75.0
Cholecystectomy	39	39	100.0	173	161	93.1	102	84	82.4	266	239	89.8	162	149	92.0
Operations on tubes and/or ovaries	29	23	79.3	53	45	84.9	28	23	82.1	55	37	67.3	44	26	59.1
Operations on uterus	66	40	60.6	164	139	84.8	165	145	87.9	403	164	40.7	116	76	65.5
Operations on thyroid	16	15	93.8	81	80	98.8	33	21	63.6	30	29	96.7	41	40	97.6
TOTAL	253	190	75.1	741	640	86.4	482	380	78.8	1253	789	63.0	520	410	78.8

in Illustration 3. The table shows that in from 63 per cent to 86.4 per cent of cases in the seven operations categorized it was unnecessary to have the charts reviewed by both the medical record librarian and the committee, yet the results were the same as though the charts had been read: Clear-cut pathological findings were accepted as justifying the surgery.

A P.A.S. monthly operation listing involving appendectomies and used by the medical record librarian in preparing for the tissue committee is shown in Illustration 4. Those cases with tissue Code 1 (tissue disease which generally requires surgical removal) are checked (✓), which means that they are dismissed as justified; those needing committee attention (Codes 2 and 3) have had their record numbers underlined.

This method does not condemn an operation merely because of normal tissue removal. It does call attention easily and graphically to those cases for which the committee should evaluate, on the basis of the clinical indications for surgery, the removal of normal or slightly diseased tissue. As a matter of fact, the tissue committee may establish ground rules which permit normal tissues in certain operations, *i.e.* the normal uterus removed for prolapse in postmenopausal patients should be considered as automatically justified. Or again, rules may be established which require that cases with tissues with a pathologist's classification of "1" also be evaluated by the committee in order to determine whether more extensive surgery should have been done. An example of this would be the *simple* mastectomy done for carcinoma of the breast. In other words, it is the tissue committee's responsibility to establish rules which will ensure the most effective evaluation of surgery done in the hospital.

A rather special class of cases is composed of the "D & C's" where the pathologist classifies the tissue strictly as to the presence or absence of disease — not on the basis that all "D & C's" are justified as diagnostic procedures. This makes it possible to screen out as not needing committee attention those with tissues coded 2 and 3, while referring to the committee certain cases, such as malignant neoplasms, with Code 1 and for which no further surgery was recorded.

The same principle of coupling diagnosis and operative procedure can be applied also to those operations in which no tissue was removed or no pathology report was made (no tissue was sent to the pathologist). Neurectomy might be dismissed from case review in the presence of a diagnosis of spastic paraplegia even though a general rule specifies that "no-tissue" operations require committee review. The hospital's practice may not require a tissue report on certain tissues in plastic surgery. Here the diagnosis and operation taken together may override a general rule requiring that every case lacking a tissue report be passed before the committee. Such time saving screening is only possible when simple and efficient data handling and presentation methods, such as the P.A.S., are in use.

The method here described will, of course, function only with a forthright pathologist. Classification of all tissue as Category 1 in an effort to help justify surgery will soon be detected by an alert committee, and it will once again be necessary to review all charts in detail. Conversely, refusal of the pathologist to use the Category 1 designation in accordance with the rules of justified surgery (on a tissue disease basis) established by the committee will also throw the entire case review load on the committee. However, given the honesty and cooperation between pathologist and surgeon which are the rule rather than the exception, the tissue committee procedure can be effectively streamlined by the application of this method. ■

4. MONTHLY OPERATION LISTING

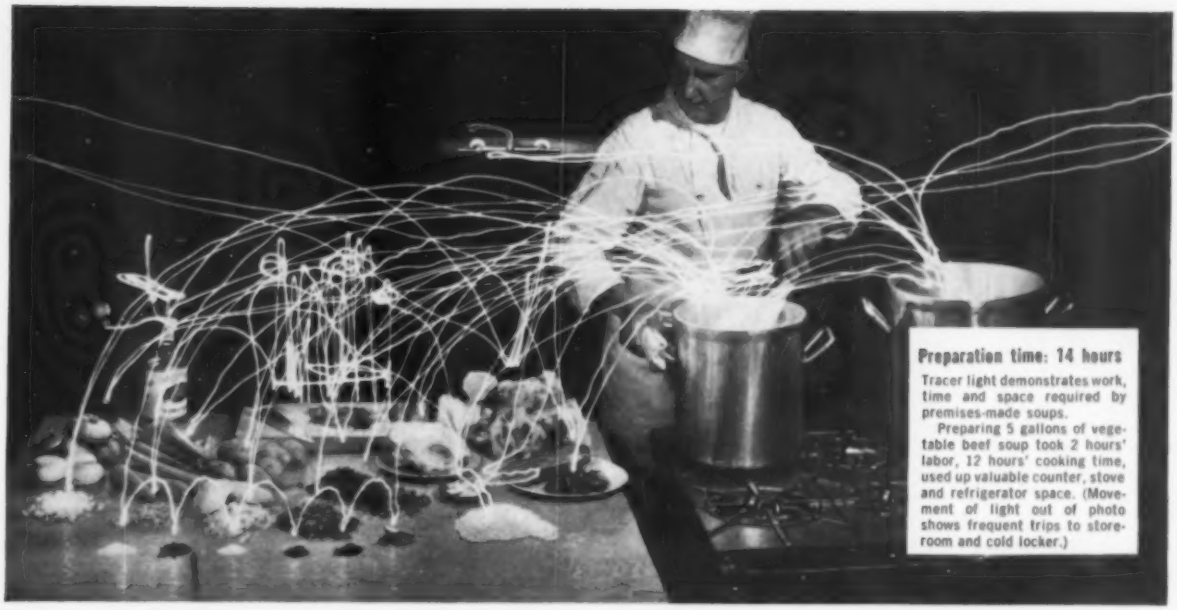
PERIOD ENDING JAN 59 INDEX OPERATION HOSPITAL HOSPITAL _ CTY _ ST _ 761

PROFESSIONAL ACTIVITY STUDY OF THE COMMISSION ON PROFESSIONAL AND HOSPITAL ACTIVITIES, INC.

[APPENDECTOMY]

Diagnosis (1)	Hospital service (6)	Operation (7)	Physician (10)	Operation data (12)	(13)	Patient number (16)	Hospital stay (17)	(19)	Age (20)	(22)	Adm (23)	(28)	Hematology (29)	Hb or Hct (30)	Total WBC (31)	(32)	Therapy (40)	(42)
468.1	62	661-12	28	28	30	6911	4	2	21	1	12	3	5	13	[illegible]		7	4
550.0	62	661-12	29	29	1 ✓	6960	3	1	13	1	15						2	4
550.0	62	661-12	89	89	1 ✓	6800	5	2	30	1	14	3	5	13	14		72	9
550.0	62	661-12	14	62	1 ✓	6371	3	1	31	1	15	3	5	16	23	1	2	4
550.0	62	661-12	66	80	1 ✓	6321	5	1	42	1	25	3	5	13	15	1	72	4
550.0	62	661-12	63	63	1 ✓	7072	3	1	16	1	16	3	5	16	21	1	2	2
550.0	62	661-12	79	79	1 ✓	6852	6	2	15	1	23	3	5	13	16		72	4
550.0	62	661-12	80	80	3	6617	4	1	12	1	13	3	5	14	10	5	72	2
550.0	62	661-12	84	17	1 ✓	7047	5	1	29	1	24	23	5	14	10	1	72	4
550.0	62	661-12	87	80	32	6443	4	1	28	1	04	3	5	15	12	1	72	2
550.0	62	661-12	19	19	2	6343	4	1	5	1	13	3	5	12	10		7	2
550.0	62	661-12	80	80	3	7019	3	2	8	1	24	3	5	12	10		72	2
550.2	62	661-12	17	17	3	6610	4	1	8	1	05	23	5	13	10			2
552.1	62	661-12	17	17	3	7094	4	2	9	1	14	3	5	12	9			2
552.1	62	661-12	5	98	3	6413	4	1	11	1	22	3	5	13	18		72	2
552.1	62	661-12	63	63	3	6738	6	1	38	1	04	3	5	16	01		72	2
552.2	62	661-12	871	98	3	6972	7	1	10	1 1	04	3	5	13	9		7	2
						17*												

All patients undergoing surgery are listed, with each line abstracting the patient's clinical record. All cases of the same operation are grouped together. In this example (primary appendectomies) cases dismissed from tissue committee review have been checked; charts to be read in detail are underlined. Note that for Surgeon 80 (column 12) three of the four cases show normal tissue (code 3, col. 12). Only one patient (case on second line) failed to receive laboratory workup. Of the 17 cases, 12 received antibacterials (code 7, col. 40).



Preparation time: 14 hours

Tracer light demonstrates work, time and space required by premises-made soups.

Preparing 5 gallons of vegetable beef soup took 2 hours' labor, 12 hours' cooking time, used up valuable counter, stove and refrigerator space. (Movement of light out of photo shows frequent trips to storeroom and cold locker.)

Save man-hours, please patrons

Campbell's time: 15 minutes

Preparation takes little counter and stove space – one burner is used for only a few minutes.

Small batch can be made up quickly. No refrigerator space required. The soup you serve contains all the ingredients of the premises-made soup shown above, yet all you do is open can, pour into kettle, add water and heat.

with Campbell's quality Soups

Scientific studies in commercial kitchens show that Campbell's Soups mean substantial savings in ingredients—and in time, space and man-hours you can profitably employ for other purposes. Yet there's no compromise with quality when you serve Campbell's Soups. For Campbell's uses the finest ingredients and prepares them with the same professional care that you insist on in your own kitchen.

And when you consider the number of different Campbell's Soups – all with proven taste appeal – you'll see the opportunity for menu variety that increases soup sales. Especially when you personalize your soups with your own seasonings and garnishes.

Campbell Soup Company

Institutional Division, Camden 1, N. J.

Idea: Create your own soup from two Campbell's Soups. Try Purée Mongol—1 can Cream of Tomato, one can Green Pea—season to taste for a dramatic, exciting menu sensation that sets up appetites.

CHOOSE FROM EIGHTEEN 50-OUNCE SOUPS

For additional information, use postcard facing Cover 3.

ABOUT PEOPLE

Administrators


Robert A. Anderson

Robert A. Anderson, assistant director of the Sloan Institute of Hospital Administration at Cornell University, has been appointed to succeed **Walter R. Amesbury** as administrator of Waltham Hospital, Waltham, Mass. Mr. Amesbury's resignation was announced in the February issue of The MODERN HOSPITAL. Mr. Anderson will assume his new position in July. Before going to Cornell in March 1957, Mr. Anderson was superintendent of the Wyoming County Community Hospital, Warsaw, N.Y., beginning in 1948. He holds a master's degree in hospital administration from Columbia University and is a fellow of the American College of Hospital Administrators.

Harold E. Wetzel has been named administrator of Miners Hospital of North Cambria, Spangler, Pa. Mr. Wetzel was formerly administrator of Anniston Memorial Hospital, Anniston, Ala. His successor there was announced in The MODERN HOSPITAL last month. Mr. Wetzel is a graduate of the University of Toronto program in hospital administration.

Donald F. Smith, superintendent of Minneapolis General Hospital, Minneapolis, since July 1955, has resigned to become administrator of Clifton Springs Sanatorium and Clinic, Clifton Springs, N.Y. He had formerly been assistant director of the Rochester, N.Y., regional hospital council.

Harris B. Jones has been appointed administrator of Community General Hospital, Sterling, Ill., succeeding **Paul A. Bjork,** whose new appointment was announced in The MODERN HOSPITAL in April. Mr. Jones is a graduate of the University of Chicago program in hospital administration and is a fellow of the American College of Hospital Administrators. Previously he had been administrator of Washington County Hospital, Washington, Iowa.

Cheney Ellerbe has been appointed administrator of Fort Lauderdale Beach Hospital, Fort Lauderdale, Fla. He was formerly administrator of Fairmont General Hospital, Fairmont, W. Va. He will receive a master's degree in hospital administration from Northwestern University in June.

Joseph J. Potorski has been appointed assistant administrator of South Side Hospital, Bay Shore, Long Island, N.Y. Mr. Potorski was formerly administrator of North Adams Hospital, North Adams, Mass. He was a member of the class of 1950, school of public health and administrative medicine, Columbia University.


Frank A. Lynch

Frank Allan Lynch has been appointed administrative assistant at Presbyterian-St. Luke's Hospital, Chicago. He has been associated with the St. Luke's division since March 1951 as director of patient services. Prior to that he was administrative assistant in the program in hospital administration at Northwestern University for three years. Mr. Lynch is a graduate of the Bellevue Hospital School of Nursing. He attended Columbia University and New York University and is a graduate of the program in hospital administration at Northwestern University.

Joseph K. Summers has been appointed director of finance of the Antillas Clinic Medical Staff, Inc., in Rio Piedras, Puerto Rico. Mr. Summers is a professor of management at the University of Puerto Rico and was formerly administrative consultant to the hospital. The post of director of finance succeeds the position of hospital administrator which has been eliminated in the new organization structure of the institution.

Sister Roberta has been named administrator of O'Connor Hospital, San Jose, Calif., following four and one-half years as administrator of Hotel Dieu Hospital, El Paso, Tex. She replaces **Sister Helen,** who had served as administrator since September 1954. Prior to her assignment in El Paso, Sister Roberta was administrator of St. Vincent's Hospital, Los Angeles, for seven years. She had also served as administrator of De Paul Hospital, St. Louis, where she opened the school of nursing which she served as director for several years. Sister Roberta is a graduate of De Paul University, Chicago, and has taken courses in hospital administration at St. Louis University. She is a fellow of the American College of Hospital Administrators.

Manfred Flam has been appointed assistant to the director of Mount Sinai Hospital, Hartford, Conn. He had been assistant superintendent at McCook Memorial Hospital, Hartford, Conn.

Elbert E. Gilbertson has been appointed assistant administrator of St. Luke's Hospital, Boise, Idaho. He is a graduate of the University of Minnesota course in hospital administration and has been a member of the faculty for the course.

T. Ray Jones has been appointed administrator of Jackson-Madison County General Hospital, Jackson, Tenn. A graduate of the Northwestern University course in hospital administration and a member of the American College of Hospital Administrators, he has for the last six years been administrator of North Mississippi Community Hospital, Tupelo.

W. Delmer Brown has been appointed administrator of Corpus Christi Osteopathic Hospital, Corpus Christi, Tex. He was formerly administrator of Elizabethtown Clinic, Elizabethtown, Ky., and Clinton County Memorial Hospital, Albany, Ky. Mr. Brown is a graduate of the University of Cincinnati College of Law and received additional training in hospital administration at the University of Kentucky and the University of Louisville.

J. Boyd Collard, administrator of City Hospital, Okmulgee, Okla., since 1953, has become administrator of McAlester General Hospital, McAlester, Okla.

Lyle Sale has been appointed administrator of Glenn General Hospital, at Willows, Calif., succeeding **Bert Pugatch.**

(*Continued on Page* 196)

THE ULTIMATE IN CUTTING EFFICIENCY

And now these traditionally sharper carbon steel blades are available sterile in puncture-resistant, reinforced foil packages. (The unopened package can be autoclaved, if desired.)

A TIME-TESTED PRODUCT IN A TIME-SAVING PACKAGE ▶▶

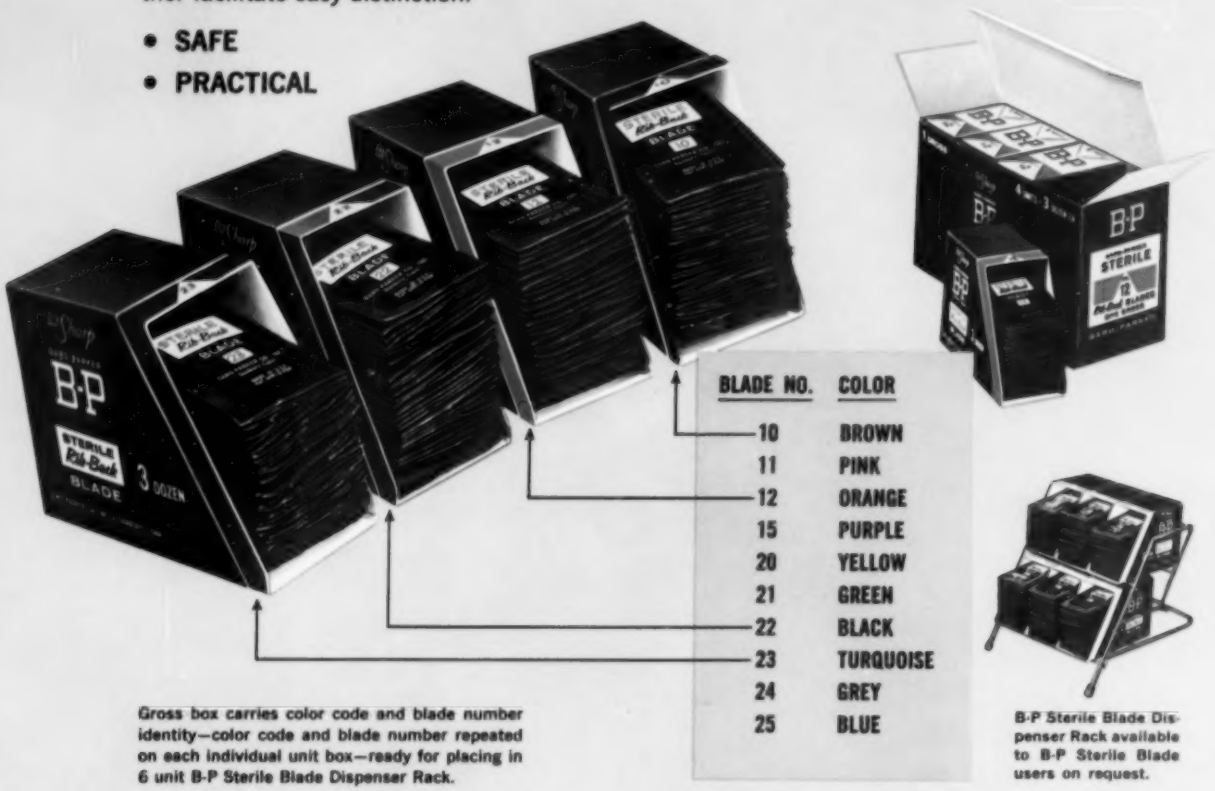
Setting a Standard in

COLOR CODING

a TIME and LABOR saver

Keeping pace with the B-D products already setting a standard in color coding... B-P STERILE Rib-Back Blade boxes are now color coded to further facilitate easy distinction.

- SAFE
- PRACTICAL



BLADE NO.	COLOR
10	BROWN
11	PINK
12	ORANGE
15	PURPLE
20	YELLOW
21	GREEN
22	BLACK
23	TURQUOISE
24	GREY
25	BLUE

Gross box carries color code and blade number identity—color code and blade number repeated on each individual unit box—ready for placing in 6 unit B-P Sterile Blade Dispenser Rack.

B-P Sterile Blade Dispenser Rack available to B-P Sterile Blade users on request.

COLOR CODING

on Wilson surgeons' gloves simplifies size identification, saves sorting time. Every Wilson surgeons' glove—white latex, brown latex and brown milled—is available color-banded according to uniform industry practice.

SIZE	COLOR
6½	BLUE
7	RED
7½	BLACK
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6,8½,10	YELLOW

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—increases the purchasing power of your budget dollar by releasing personnel sooner for other duties.

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DANBURY, CONNECTICUT
A DIVISION OF BECTON, DICKINSON AND COMPANY

Prototype Study: 200 Bed Hospital

Continuing a new series of "Prototype Studies" of hospital operations and activities, with up-to-date information on principal departments. This expanded prototype study of the 200 bed general hospital analyzes operations in greater detail than has ever been done before. It also points out major changes in operation and utilization that have occurred during the last seven years. It is recognized that not all of the available data presented are current. For this reason the information is prepared in tabular form showing the approximate year in which data were available. Subsequent studies present similar information describing hospitals in other size groups.

Louis Block, Dr. P.H.

THE 200 bed general nonprofit hospital usually provides medical, surgical, obstetrical, pediatric and orthopedic services.

Bed Distribution

It is common practice for this hospital size group to combine medical and surgical beds in certain nursing areas as well as to have specific bed assignments for medical, surgical, obstetrics, pediatric and orthopedic patients.

As a rule, no distinct assignment of beds is made for isolation, chronic, psychiatric or tuberculosis patients.

Bed distributions between the various services has remained fairly constant although there is a slight reduction in the number of obstetrical beds. It is in this size group that a specific bed assignment is first made for orthopedic cases.

The average 200 bed general hospital will have 135 medical-surgical beds, 32 obstetrical beds, 28 pediatric beds, and 5 orthopedic beds.

Utilization

The utilization pattern has shown a continuing increase in the last five years. Admissions have increased 11 per cent and births have increased 8 per cent. The number of newborn days of care has decreased showing an accompanying decreased length of stay of newborn infants.

Financial

Along with the increased utilization, the investment in and costs of providing services have also increased. Total assets have increased 57½ per cent while investment in plant has increased 74 per cent. This means that a greater proportion of the hospital's assets is tied up in plant.

Payroll is responsible for the greatest part of the increase in expenses. In fact, payroll accounted for almost two-thirds of the 37 per cent increase in expenses in the last five years for this hospital group.

The changing practice of medicine has resulted in an increased proportionate allocation of expenses to laboratory, x-ray and pharmacy.

Despite the increase in cost of operation, total income more than offsets the cost. However, a greater proportion of expenses will be covered by income from sources other than patients than in the past.

Services

A greater proportion of the 200 bed general hospital group is providing special services than ever before. When services are provided by more than half of the hospitals they are considered basic. Formerly, basic services in the 200 bed general hospital included:

1. Blood bank
2. Central supply room
3. Clinical laboratory
4. Electrocardiograph
5. Hospital auxiliary
6. Medical library
7. Patient library
8. Medical record department
9. Metabolism apparatus
10. Outpatient department
11. Pharmacy
12. Physical therapy department
13. Premature nursery
14. X-ray diagnosis
15. X-ray therapy
16. Obstetrical delivery rooms
17. Operating rooms
18. Emergency

To this group the following additional services are now considered basic:

1. Postoperative recovery room
2. School of nursing

Rapidly approaching the level of being considered basic are:

1. Cancer clinic
2. Dental department
3. Radioactive isotopes
4. Routine chest x-ray on admission

(*Continued on Page* 104)

Personnel

Although utilization is increasing, the number of personnel required to provide the services rendered is increasing at a greater rate. This, in turn, is reflected in increased costs and payroll. Increases in personnel are especially noted in the nursing, laboratory and x-ray departments. In the last five years, personnel in x-ray has increased 33 per cent, in laboratory it has increased 66 per cent, and in nursing it has increased 28 per cent.

Laboratory

The hospital will have a staff member specializing in pathology. He will be full time. It will require all tissue removed at surgery to be routinely examined by the pathologist, urinalysis on all admissions, blood count on all adult admissions, serological examination on all adult admissions, and preoperative coagulation tests on all tonsillectomies.

It will have a blood bank and will obtain most of its blood directly from donors. There is an increasing tendency to provide more laboratory work per patient, from 0.7 examinations per patient day to 1.3 examinations per patient day. The laboratory facilities will be available to private ambulatory patients of physicians.

X-Ray

The hospital will have a staff member specializing in radiology. He will be on a full-time basis. The x-ray facilities of the hospital will be available to private ambulatory patients of physicians.

Pharmacy

The hospital will have a pharmacy. It will have one or two full-time licensed pharmacists, will not manufacture parenteral solutions, and will have a formulary.

Medical Staff

The hospital will have a chief of staff and chiefs of services, written staff regulations, regularly scheduled meetings of the staff, standing committees, and will provide for surgical restrictions on staff. It will also have an executive committee, medical record committee, credentials committee, tissue committee, educational committee, and pharmacy committee. The hospital will have a psychiatrist on its staff and it will be accredited by the Joint Commission.

Admitting

The hospital will generally use a typewriter for duplicating admitting records. It will routinely treat cancer, cardiac, dermatology, gynecology, medical, neurology, obstetrical, opthalmology, orthopedic, otorhinolaryngology, surgical and urology patients. Its services are generally for the acutely ill, although it will accept chronically ill, industrial and pediatric patients.

If the hospital does admit psychiatric patients, it will not provide a separate facility for such purposes.

Other Considerations

The 200 bed general hospital will employ dietitians, have a central food service, will provide some kind of selective menus for patients, have mechanical and centralized dishwashing, use gas for cooking, operate its own laundry and process all its soiled linen, and have an administrator who is other than a nurse or a physician. It will calculate depreciation, but will not fund it; it will use the A.H.A. chart of accounts but may or may not operate under a formal budget, and it will charge for drugs on the nursing floors. There is a greater tendency to charge all groups (private, semiprivate and ward) the same for laboratory, x-ray and other special services.

AVERAGE DAY'S ACTIVITIES

	1953 Prototype	1956 Prototype	1958 Prototype
Admissions	19	20	21
Medical	6	6	....
Surgical	7	7	....
Obstetrical	3-4	4	....
Pediatric	2-3	3	....
Adult Census	154	150	154
Medical-surgical	115	108-110	....
Pediatric	21	21-22	....
Obstetric	18	19-20	....
Private	17	....	....
Semiprivate	76	....	....
Ward	61	....	....
Births	4	4	4
Newborn census	22	20-21	20
Operations	10	....	....
Major	4	....	....
Minor	6	....	....
X-ray examinations	35	....	....
Inpatients	21	....	....
Outpatients	10	....	....
Private ambulatory	4	....	....
X-ray treatments	5-6	5-6	....
Meals served	956-984	1,000	1,075
Patients	451-465	450	450
Employes and other	505-519	550	625
Laboratory examinations	132-137	....	280
Inpatient	....	....	200
Outpatient	....	....	80
Personnel	227	245	270
Patient income	$2,822-$2,849	$3,200	$3,975
Expenses	$3,014	$3,500	$4,175
Payroll	$1,753-$1,781	$2,000	$2,510

AVERAGE DAY'S ACTIVITIES, Cont.

	1953	1956	1958
Laundry (pounds)	1,863	2,200	....
Outpatient visits	....	83-86	....
Clinic visits	....	46-47	45
Emergency visits	....	13-14	14
Private outpatient visits	....	24-25	....

BED DISTRIBUTION

	1953	1956	1958
Number of medical-surgical beds	138	....	135
Number of obstetrical beds	35	....	32
Number of pediatric beds	27	....	28
Number of orthopedic beds	....	....	5
Per cent beds medical-surgical	69	....	67-68
Per cent beds obstetrical	17½	....	16
Per cent beds pediatric	13½	....	14
Per cent beds orthopedic	....	....	2-3
Number of private beds	26	....	....
Number of semiprivate beds	90	....	....
Number of ward beds	84	....	....
Per cent hospitals allocating beds for isolation or contagious patients	20	20	18
Per cent hospitals allocating beds for chronic patients	5	7	7
Per cent hospitals allocating beds for psychiatric patients	10	10	3
Per cent hospitals allocating beds for tuberculosis patients	4	4	3
Of those hospitals allocating beds average number of such beds for			
Isolation or contagious	9	9	8
Chronic	25-26	20	20
Psychiatric	21	21	12
Tuberculosis	24	24	35

(Continued on Page 106)

WHAT'S DIFFERENT ABOUT DAVOL URINE DRAIN TUBES?

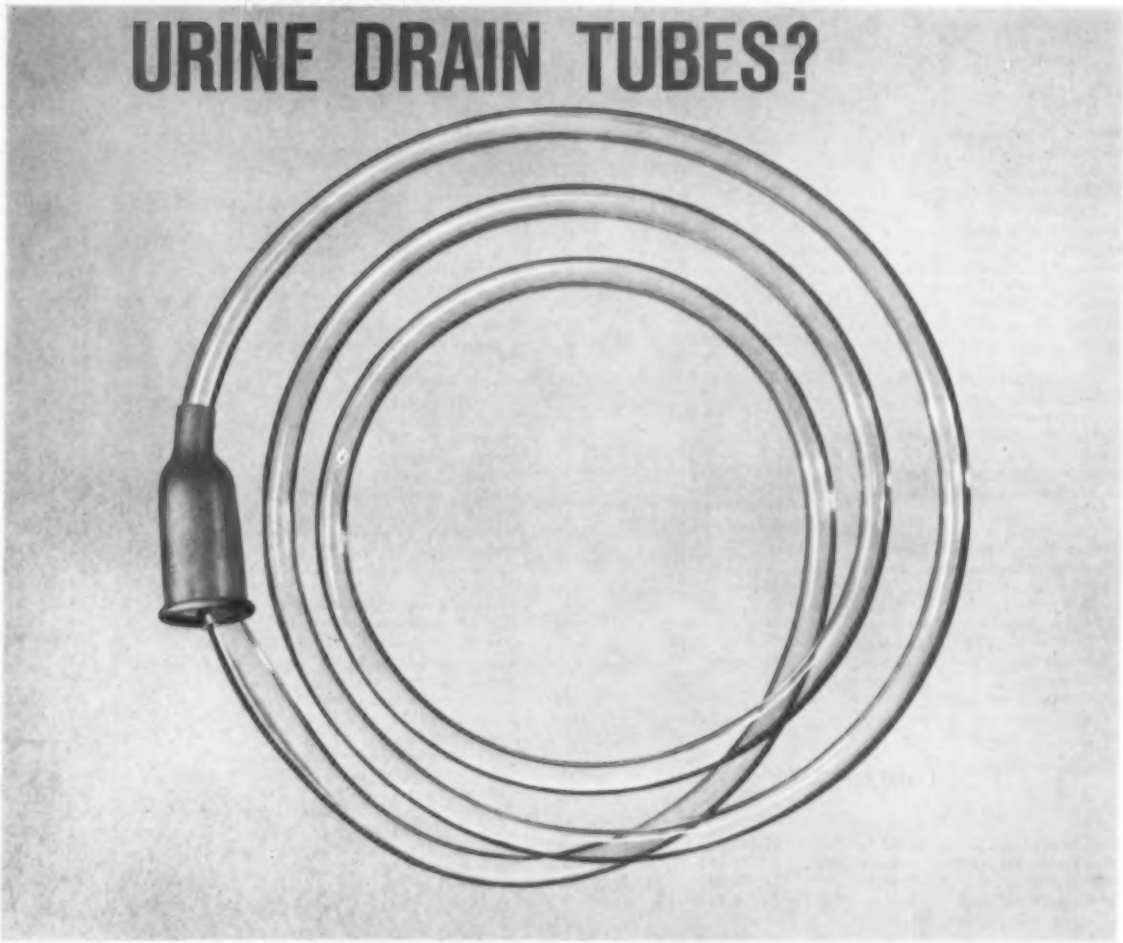
Adapter Cap will not split *when stretched to go over bottle—provides tighter fit.*

Vent holes in Cap prevent vacuum, *allow steady fluid flow.*

Cap cannot pull off tube—*Cap is placed beyond a tapered funnel. The more tension on the cap the tighter the fit.*

No further parts—*Design of tube means no further parts are necessary to connect catheter to receptacle.*

Can be sterilized *by cold solution, boiling or autoclave and re-used.*



Davol Urine Drain Tubes are designed for maximum convenience of the user. For further information on the complete line of Davol Urinals and Accessories, contact your hospital supply dealer or write Davol Rubber Company, 69 Point St., Providence 2, R.I.

3605—Disposable Drain Tube with adapter cap. 3/16" lumen, 5' length.

3606—(illustrated) Disposable Drain Tube with adapter cap. 9/32" lumen, 5' length.

To place in use, simply pull tube ends apart. No covers, plugs or cotton to be removed.

DAVOL RUBBER COMPANY

BED DISTRIBUTION, Cont.

	1953	1956	1958
Per cent hospitals having closed beds	12	....	....
In those hospitals having closed beds, average number of beds closed	24	....	....
Per cent hospitals having beds closed because of lack of personnel	6	....	....
In those hospitals having beds closed because of lack of personnel, average number of beds closed	23	....	....
Per cent hospitals having beds closed for reasons other than lack of personnel	6	....	....
In those hospitals having beds closed for reasons other than lack of personnel, average number of beds closed	27	....	....

UTILIZATION

	1953	1956	1958
Number of admissions	6,800-6,900	7,300	7,600
Medical	2,100-2,125	2,263	....
Surgical	2,375-2,400	2,482	....
Obstetrical	1,325-1,350	1,460	....
Pediatric	1,000-1,025	1,095	....
Per cent of admissions			
Medical	31	31	....
Surgical	35	34	....
Obstetrical	19	20	....
Pediatric	15	15	....
Admissions per bed	34-35	36-37	38
Number of live births	1,350	1,400	1,460
Number of prematures	80-85	85	....
Number of sets of twins	14	14	....
Number of stillbirths	16	18	....
Number of patient days of care, adult	56,000	54,750-55,000	56,210
Obstetrical days	6,500	7,000	....
Medical-surgical days	42,000	40,000	....
Pediatric days	7,500	8,000	....
Number of newborn infant days of care	8,000	7,500	7,300
Average daily adult census	154	150	154
Medical-surgical	115	108-110	....
Obstetrical	18	19-20	....
Pediatric	21	21-22	....
Average daily newborn census	22	20-21	20
Percentage of occupancy, adult	76	75	77
Private	60-70	....	....
Semiprivate	75-85	....	....
Ward	65-75	....	....
Medical-surgical	80-85	80	....
Pediatrics	75-80	63	....
Obstetrics	50-55	70	....
Percentage of occupancy, newborn	63	60	57
Average length of patient stay in days	8	7.5	7.4

FINANCIAL

	1953	1956	1958
Total assets	$2,000,000	$2,450,000	$3,150,000
Total assets per bed	$ 10,000	$ 12,250	$ 15,500
Plant assets	$1,300,000	$1,750,000	$2,260,000
Plant assets per bed	$ 6,500	$ 8,750	$ 11,300
Per cent plant assets of total assets	65	72	73
Total expenses	$1,100,000	$1,270,000	$1,525,000
Expenses per patient day	$ 19.75	$ 23.25	$ 27.15
Private	$ 23-$24	....	....
Semiprivate	$ 19-$20	....	....
Ward	$ 18-$19	....	....
Expenses per patient stay	$ 156	$ 175	$ 201
Annual payroll expense	$ 640,000-$ 650,000	$ 745,000	$ 916,000
Average annual salary per employe	$ 2,300	$ 2,380	$ 2,675
Per cent payroll of total expense	58	59	60
Payroll expense per patient day	$ 11.50	$ 13.60	$ 16.30

FINANCIAL, Cont.

	1953	1956	1958
Per cent distribution of expense by departments:			
Administration	11	11	11.9
Dietary	16	16	12.7
Housekeeping	5	5	5.0
Laundry	2-3	3	2.2
Plant operation	7	7	6.4
Medical and surgical	6	6	6.0
Operating and delivery rooms	6-7	6.5	7.2
Pharmacy	4-5	5	5.4
Nursing	25-26	26	25.0
Anesthesia	2-3	2.5	2.3
Laboratory	5-6	5	7.1
X-ray	4-5	5	5.5
Other	3-4	3.5	3.3
Annual patient income	$1,030,000-$1,040,000	$1,175,000	$1,450,000
Patient income per patient day	$ 18.50	$ 21.50	$ 25.90
Private	$ 27-$28	....	....
Semiprivate	$ 21-$22	....	....
Ward	$ 12-$13	....	....
Patient income per patient stay	$ 146	$ 162	$ 192
Per cent patient income of total expense	94	92	92
Total annual income	....	$1,300,000	$1,590,000
Total income per patient day	....	$ 23.75	$ 28.20

SERVICES

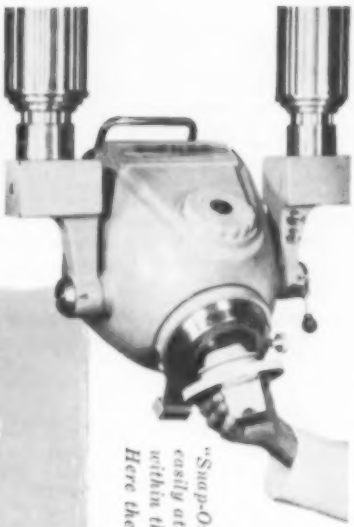
	1953	1956	1958
Per cent hospitals having:			
Blood bank	80	80	82
Cancer clinic	40	39	39
Central supply room	80	88	95
Children's educational program	12	11	11
Clinical laboratory	96	99	100
Dental department	33	38	38
Electrocardiograph	94	97	99
Electroencephalograph	20	20	23
Hospital auxiliary	70	79	86
Medical library	....	94	....
Patient library	60	64	64
Medical record department	98	99	100
Mental hygiene clinic	14	11	11
Metabolism apparatus	96	98	100
Occupational therapy	14	12	14
Outpatient department	70	65	64
Pharmacy	90	94	96
Physical therapy department	70	72	72
Postoperative recovery room	17	44	72
Premature nursery	....	73	78
Radioactive isotope	....	18	41
Rehabilitation department	....	9	9
Social service department	33	31	29
X-ray diagnosis	99	99	99
X-ray therapy	70	81	82
X-ray, routine chest on admission	25	38	48
Organized training course for auxiliary nurses	25	25	....
Obstetrical delivery room	....	....	94
Operating room	....	....	100
Emergency	....	....	97
School of nursing	46	50	....

PERSONNEL

	1953	1956	1958
Average number of full-time equivalent paid personnel (excluding interns, residents and students)	280-285	312	343
Average number of full-time employes per 100 patients	180	212	220
Average number of full-time employes per bed	1.4	1.5-1.6	1.7
Average number of full-time employes per occupied bed	1.8-1.9	2.1	2.2
Departmental distribution, number of employes:			
Administration and business office	24	24	24
Nursing	142	176	182

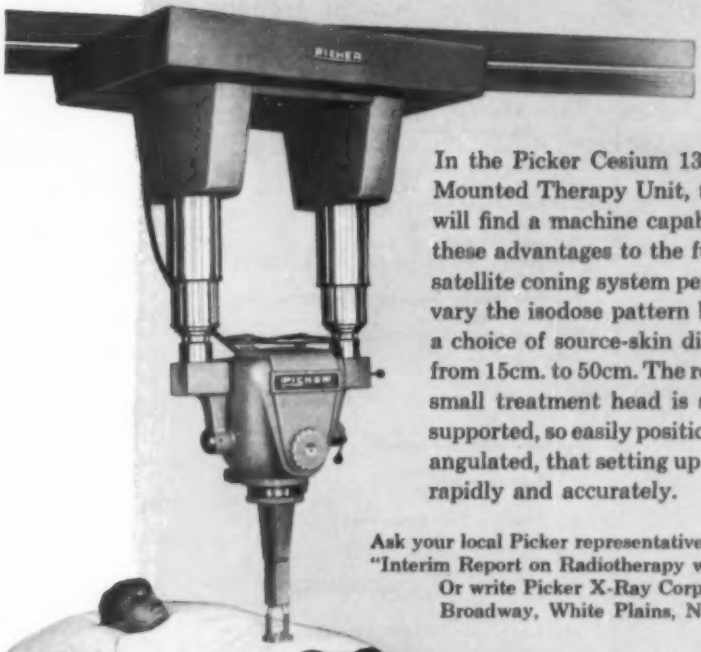
(*Continued on Page* 108)

The compact sourcehead "gets in close" for head and neck therapy at 15 cm. source-skin distance.



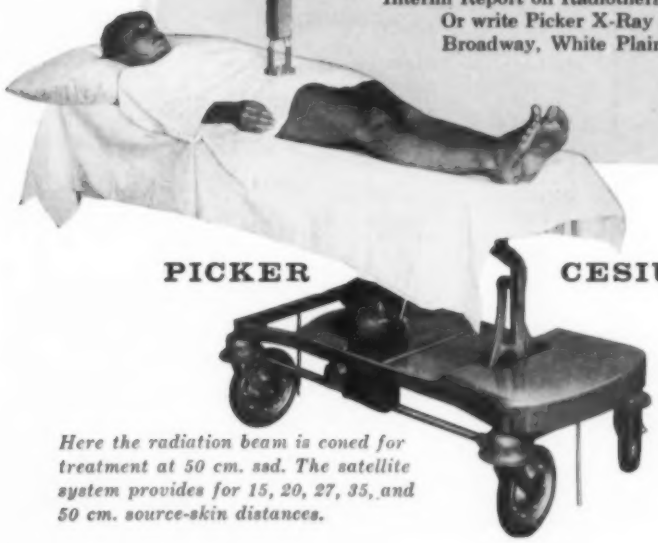
"Snap-On" cones are held in a strong magnetic grip, are easily attached or detached. Once in place, they can be rotated within the holding ring as required. Here the 15 cm. ssd cone is being attached.

The prospective abundant availability of Cesium 137 has fired the imagination of radiotherapists to a lively degree. Compared to Cobalt 60, its longer half life, its lower cost, its lesser shielding, its smaller treatment head, and its therapeutic versatility hold great promise.



In the Picker Cesium 137 Ceiling Mounted Therapy Unit, the therapist will find a machine capable of exploiting these advantages to the full. Its satellite coning system permits him to vary the isodose pattern by treating at a choice of source-skin distances ranging from 15cm. to 50cm. The relatively small treatment head is so flexibly supported, so easily positioned and angulated, that setting up the case goes rapidly and accurately.

Ask your local Picker representative for a copy of our "Interim Report on Radiotherapy with Cesium 137". Or write Picker X-Ray Corporation, 25 South Broadway, White Plains, New York.



PICKER CESIUM[137] THERAPY UNIT

Here the radiation beam is coned for treatment at 50 cm. ssd. The satellite system provides for 15, 20, 27, 35, and 50 cm. source-skin distances.

Picker X-ray

PERSONNEL, Cont.

	1953	1956	1958
X-ray	3	4	4
Laboratory	6	8-9	9-12
Dietary	37	37	38
Housekeeping	25	25	25
Plant operation	17	17	17
Laundry	13	13	13
Medical records	4	5-6	6
Pharmacy	3	3	3
Outpatient	11	....	....
Physical therapy	1	....	....
Number of nursing personnel:			
Total graduate nursing personnel (full-time equivalents)	....	88	87
Administrative	....	3	3
Instructors	....	4	4-5
Supervisors and assistants	....	8	7-8
Head nurses and assistants	....	12	12
General duty nurses			
Full-time	....	43	41
Part-time	....	18	22
Private duty nurses	....	14	11
Practical nurses	....	31-32	20
Full-time	....	....	18
Part-time	....	....	2
Attendants (in those hospitals having them)	....	25	....
Nurse's aides	....	44	....
Attendants and nurse's aides	....	....	57
Full-time	....	....	49
Part-time	....	....	8
Ward maids	....	7-8	9
Full-time	....	....	8
Part-time	....	....	1
Orderlies (in those hospitals having them)	....	....	7
Full-time	....	....	6
Part-time	....	....	1
Other auxiliary nursing personnel	....	....	8
Full-time	....	....	7
Part-time	....	....	1
Total graduate nursing personnel	....	....	99
Full-time	....	....	74
Part-time	....	....	25
Administrative nurses	....	....	3
Full-time	....	....	3
Part-time	....	....	0
Instructors	....	....	5
Full-time	....	....	4
Part-time	....	....	1
Nurse anesthetists	....	....	3
Full-time	....	....	3
Part-time	....	....	0
Operating room nurses	....	....	10
Full-time	....	....	9
Part-time	....	....	1
O. R. supervisors	....	....	1
Full-time	....	....	1
Part-time	....	....	0
O. R. head nurses	....	....	1
Full-time	....	....	1
Part-time	....	....	0
O. R. staff nurses	....	....	7
Full-time	....	....	6
Part-time	....	....	1
Patient care area nurses	....	....	74
Full-time	....	....	52
Part-time	....	....	22
Patient care supervisors	....	....	7
Full-time	....	....	6
Part-time	....	....	1
Patient care head nurse	....	....	11
Full-time	....	....	11
Part-time	....	....	0
Patient care staff nurse	....	....	56
Full-time	....	....	35
Part-time	....	....	21
Number of medical technologists			
Registered, full-time	....	4	3-4
Registered, part-time	....	0-1	0-1
Other, full-time	....	4	5
Other, part-time	....	1	1-2
Number of x-ray technicians			
Registered, full-time	....	2	2-3
Registered, part-time	....	0	0
Other, full-time	....	2	1-2
Other, part-time	....	0	0

PERSONNEL, Cont.

	1953	1956	1958
Number of pharmacists (in those hospitals having a pharmacy department)			
Full-time	....	1-2	1-2
Part-time	....	0	1
Per cent hospitals employing a graduate medical record librarian	75	....	....
Per cent hospitals employing a nongraduate medical record librarian	70	....	....
Number of medical record librarians (in those hospitals having a medical record department)			
Registered, full-time	....	1	1
Registered, part-time	....	0	0
Other, full-time	....	4	4-5
Other, part-time	....	1	1
Per cent hospitals employing a dietitian	90	....	....
Number of dietitians (in those hospitals having a dietitian)			
Full-time	....	2-3	....
Part-time	....	0	....
A.D.A. certified:			
Full-time	....	....	1-2
Part-time	....	....	0
Other dietitians			
Full-time	....	....	1
Part-time	....	....	0

MEDICAL RECORDS

	1953	1956	1958
Per cent hospitals microfilming medical records	....	36	....
Number of deaths	220	197	215
Number of institutional deaths (48 hours or over after admission)	155	....	....
Number of noninstitutional deaths (less than 48 hours after admission)	65	....	....
Per cent deaths of admissions	3.2	2.8	2.8
Number of premature fatalities	12	....	....
Number of autopsies	100	70-71	85
Per cent autopsies of deaths	45.5	35	39.5
Number of deaths released to public authorities	....	21	....
Per cent deaths released to public authorities of admissions	....	0.3	....
Per cent hospitals using standard nomenclature	....	96	....

DIETARY

	1953	1956	1958
Number of meals served	350,000-360,000	357,000	392,000
Patient meals	165,000-170,000	160,000	165,000
Employe and other meals	185,000-190,000	197,500	227,000

ADMINISTRATOR

	1953	1956	1958
Number of years administrator has been on present job			
Low	....	....	½
Median	....	....	5
High	....	....	30 plus
Annual cash salary of administrator			
Low	....	....	$ 5,014
Median	....	....	$12,500
High	....	....	$22,000
Annual value of bonuses given to administrator			
Low	....	....	$ 450
Median	....	....	....
High	....	....	$ 2,500
Annual value of living quarters provided for administrator			
Low	....	....	$ 1,146
Median	....	....	$ 1,695
High	....	....	$ 3,600
Annual value of meals provided administrator			
Low	....	....	$ 465
Median	....	....	$ 535
High	....	....	$ 3,062

(*Continued on Page 110*)

ADMINISTRATOR, Cont.	1953	1956	1958
Total annual income of administrator			
Low	....	....	$ 7,906
Median	....	....	$15,087
High	....	....	$27,512

X-RAY

	1953	1956	1958
Number of fluoroscopies	....	....	2,050
Inpatient	....	....	1,490
Outpatient	....	....	560
Number of x-ray films	....	....	19,500
Inpatient	....	....	12,000
Outpatient	....	....	7,500
Number of x-ray treatments, superficial	....	....	317
Inpatient	....	....	196
Outpatient	....	....	121
Number of x-ray treatments, deep	....	....	775
Inpatient	....	....	580
Outpatient	....	....	195

ACCOUNTING

	1953	1956	1958
Policies covering laboratory charges			
Inpatients			
Per cent of hospitals reporting			
Same rate to all	23	....	45
Only ward different	40	....	40
Different rate to all	32	....	6
Flat rate to all	4	....	1
Clinic patients			
Per cent hospitals reporting			
Same rate as ward	38	....	32.5
Different rate from ward	52	....	47.5
Same rate as private	10	....	20
Private ambulatory patients			
Per cent hospitals reporting			
Same rate as private	95	....	93
Same rate as semiprivate	3	....	0
Different rate to all	2	....	7
Policies covering x-ray charges			
Inpatients			
Per cent hospitals reporting			
Same rate to all	15	....	34
Only ward rate different	47	....	49
Different rate to all	40	....	13
Only private rate different	....	....	13
Clinic patients			
Per cent hospitals reporting			
Same rate as ward	42	....	30
Different rate from ward	51	....	51
Same rate as private	7	....	19
Private ambulatory patients			
Per cent hospitals reporting			
Same rate as private	95	....	98
Same rate as semiprivate	5	....	....
Same rate as clinic	....	....	2
Usual charges for operating room, anesthesia and other services			
Basal metabolism			
Private patient	$10	....	$10
Semiprivate patient	$10	....	$10
Ward patient	$ 5	....	$10
Outpatient	$ 5	....	$ 5
Private ambulatory patient	$10	....	$10
Electrocardiograph			
Private patient	$15	....	$15
Semiprivate patient	$15	....	$15
Ward patient	$10	....	$10
Outpatient	$ 5	....	$10
Private ambulatory patient	$15	....	$15
Cystoscopy			
Private patient	$15	....	$25
Semiprivate patient	$15	....	$25
Ward patient	$ 5	....	$15
Outpatient	$10	....	$15
Private ambulatory patient	$15	....	$15
Bronchoscopy			
Private patient	$10	....	$25
Semiprivate patient	$10	....	$25
Ward patient	$10	....	$25
Outpatient	$10	....	$10
Private ambulatory patient	$10	....	$25
Gastroscopy			
Private patient	$15	....	$25
Semiprivate patient	$10	....	$25

ACCOUNTING, Cont.	1953	1956	1958
Ward patient	$10	....	$25
Outpatient	$10	....	$15
Private ambulatory patient	$15	....	$15
Tonsils and adenoids (child's flat rate)			
Private patient	$25	....	$40
Semiprivate patient	$25	....	$30
Ward patients	$25	....	$20
Outpatient	$20	....	$35
Private ambulatory patient	$25	....	$55
Operating room, major			
Private patient	$30	....	$30
Semiprivate patient	$25	....	$30
Ward patient	$15	....	$30
Operating room, minor			
Private patient	$15	....	$25
Semiprivate patient	$15	....	$25
Ward patient	$10	....	$25
Anesthesia, major			
Private patient	$20	....	$15
Semiprivate patient	$20	....	$15
Ward patient	$15	....	$15
Anesthesia, minor			
Private patient	$10	....	$15
Semiprivate patient	$10	....	$15
Ward patient	$10	....	$ 5

LABORATORY

	1953	1956	1958
Total number of laboratory examinations	48,000-50,000	....	85,000
Inpatient	42,000	....	74,000
Outpatient	6,000	....	11,000
Private ambulatory	2,000	....	....
Number of inpatient examinations per patient day	0.7	....	1.3
Number of hematology examinations	....	....	44,300
Inpatient	....	....	39,200
Outpatient	....	....	5,100
Number of blood chemistry examinations	....	....	7,125
Inpatient	....	....	6,050
Outpatient	....	....	1,075
Number of urinalysis examinations	....	....	9,450
Inpatient	....	....	8,900
Outpatient	....	....	550
Number of pathology specimens, gross	....	....	1,195
Inpatient	....	....	1,090
Outpatient	....	....	105
Number of pathology examinations, microscopic	....	....	1,630
Inpatient	....	....	1,470
Outpatient	....	....	160
Number of electrocardiograph examinations	....	....	1,805
Inpatient	....	....	1,360
Outpatient	....	....	445
Number of basal metabolism examinations	....	....	352
Inpatient	....	....	166
Outpatient	....	....	186
Number of serology examinations	....	....	5,790
Inpatient	....	....	5,150
Outpatient	....	....	640
Number of bacteriology examinations	....	....	1,720
Inpatient	....	....	1,510
Outpatient	....	....	210
Number of spinal fluid examinations	....	....	223
Inpatient	....	....	217
Outpatient	....	....	6
Number of stool examinations	....	....	369
Inpatient	....	....	300
Outpatient	....	....	69
Number of other laboratory examinations	....	....	11,041
Inpatient	....	....	8,587
Outpatient	....	....	2,454

OUTPATIENT DEPARTMENT

	1953	1956	1958
Number of clinic visits	24,000	17,000	15,600
Number of emergency visits	5,000	8,750	5,000
Number of private outpatient visits	....	4,800	....

Conducted by Grover C. Bowles Jr.

The Significance of Pain to Health Care

Pain, the author suggests, is an administrative problem of the first order. It's the distinguishing characteristic between acute and chronic cases, and health care planners would do well to learn how to cope with it administratively

E. M. Bluestone, M.D.

OF ALL the manifestations of illness pain takes a commanding place in its ability to produce a positive response from philanthropist and legislator, as well as from physician, nurse and social worker. In its power to compel an attempt at relief it is on a par with such other acute symptoms as hemorrhage, shock, fever and unconsciousness. It is expressed in a call for help which cannot be denied with impunity.

Pain draws attention to itself and cries out unashamedly for relief. It serves notice that something has gone wrong, and perhaps progressively wrong, and must therefore be dealt with at once. Anyone who turns away from a person who is in pain must find it difficult to live with his conscience.

This symptom points up in a startling as well as practical way the vital role which time and distance play in the arrangements for hospital and all other medical care. In hospital organization and administration promptness of response enables us to distinguish between the sympathetic person who is desirable because his reaction is immediate, and the callous one whose reaction is delayed or absent.

The importance of the subject to the hospital administrator can hardly be overestimated. Pain is the most effective spur to action that we know. There is a compulsion which surrounds this phenomenon in the admitting office and it cannot be denied. It takes a sadist, or a criminal blinded by vengeance, or a psychopath, to stand by and disregard such a symptom. The responsibility of the hospital administrator in situations like these should be so strong and his reaction so prompt that he will "overadmit" if this is the method of choice in order to facilitate relief.

Symptoms like pain go far to justify a voluntary hospital's selective policy of bed conservation for the benefit of the acutely sick patient, and the law protects such an institution against disagreement. When a hospital is compelled to exercise a choice because of a shortage of beds, it should give preference to the sicker applicant in terms of acuteness, or urgency, rather than to the one who may be sicker in the pathological sense of the word but can wait, if only because he has already waited so long! The symptom of pain, if severe enough, can nullify all policies, rules and regulations and compel individualization of care.

A Many-Leveled Thing

There are many levels, or degrees, of pain. People have a variable threshold in response to each of these levels, and comparative need dominates our planning and our policies. Pain may or may not be self-limited and end spontaneously, having registered its warning of more, or worse, to come. In any case its threat is so pointed that it is always safer to look upon it as a danger signal. There is a subjective and objective aspect to this magnetic call. It may mean one thing to him who suffers from its baneful influence and another to him who must be impressed by it. Unfortunately for our hospitals, sympathy has human limitations which depend on patience as well as the power to help.

A condition which is nerveless, in the anatomic or pathologic sense, may be "painful" too. One person may be "painful" to another because of a variety of environmental factors which influence the struggle for life in a competitive world, including the little world of the hospital. An insult "pains" most people. Disappointing experience may be "painful" in more than a rhetoric or figurative sense. Even as an evocative figure of speech, pain can be very significant. The memory of it is never lost, with the doubtful exception of the pain of childbirth, and a recurrence is usually avoided. And let us not forget the Latin origin of the word passion, which is "to suffer."

Sensitiveness to unfriendly irritants and unhappy experience modifies the case but remains a contributing factor in the production of pain. Tenderness that is evoked only by the touch or by pressure can bring this important symptom to the surface. It is a dangerous assumption to speak casually of "exaggerated pain," because we do not have a mechanical device by which its relation to its host can be measured accurately, either quantitatively or

Dr. Bluestone is consultant, Montefiore Hospital, New York.

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qualitatively, for any particular individual. Statistics on the subject are suggestive only and not decisive. We must play it by ear, so to speak, in all of its stages.

Pain can be a great teacher, as well as disciplinarian, from whom we learn early in life to avoid those conditions which tend to produce it. The threat of pain has its own high degree of potency when men meet, or plan to meet, on the battlefield, in a criminal encounter, or in the arena. It is a symptom that is universally feared among living things and perhaps more so by thinking and sensitive humanity. We learn to keep our distance from its causes, to circumvent them, or somehow to neutralize them, as part of our education in living, and are taught further how to seek help, as well as to offer it effectively, in such emergencies. When death finally comes, the lucky one is he who does not awaken from his last peaceful sleep, and the unlucky one is he who suffers a long and restless night of pain till the end. Intractable pain is not only difficult to endure, it is heartrending to behold. Much has been written, as well as thought and felt, on the acuteness and significance of "heartache" as a manifestation of mental pain but the fact of its existence, and its strong resemblance to the organic or physical sense of menacing acuteness, must be taken into consideration. The rhetorical form of pain, centering in the most vital single organ of the human body, bears a strong resemblance to the other form and can be equally devastating though less agonizing.

Most of the painful stimuli in health and in disease can be identified or located with the help of experience or textbook descriptions. Clinicians differentiate between sharp and dull aches and pains, acute and chronic pain, and we classify and assign our patients to various locations. Where expected pain is absent, from whatever pathological cause, or where it subsides suddenly without a subsidence of accompanying signs and symptoms, we may be confronted with a serious therapeutic problem. The medical student is taught not to exhibit narcotic medication till causes can be traced and a helpful diagnosis established. Some pain, mostly in the form of discomfort, must be endured temporarily as the least of two or more evils, and particularly so when certain procedures, like instrumentation, must be carried out. In all cases, however, pain must be reduced to a minimum if it cannot be abolished altogether. It is an unwelcome restraint to therapeutic effort.

In our hospitals we are not always aware of the fact that there may be a considerable difference between pain which arises from causes within and pain that is inflicted from without, and that nervous anticipation aggravates matters. Pain can be unendurable at times to both sides and the earliest generations doubtless moved heaven and earth in their search for the drug that would provide relief, regardless of the consequences of the persistence of the etiological factors. The pharmacologic method of relieving pain by the administration of narcotic drugs is one of the oldest methods of giving "medicine" that we know.

Where medical care is not yet curative, bearable pain is sometimes looked upon by the man of superior character as a challenge which he must surmount by compensatory effort. In other instances, it can exhaust its host, and demoralize him, exercising a tyranny over him which may

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break his will to survive. The element of hope sustains most people who are compelled to wait for the tide to turn and no hospital should fail to note, and make use of, the power for good which is inherent in it.

Martyrdom, which involves the acceptance of avoidable pain in a final desire for purification, need not concern the practical hospital administrator here. It belongs in the realm of theology and the faith on which it is based. We are taught that heaven is kinder to him who bears his cross meekly, or who anticipates the final judgment of absolution by accepting his expiation on earth. The hospital chaplain can supplement the healing efforts of the physician; he can never replace him.

Every hospital administrator knows how the agonizing symptom of pain in one patient can unnerve all other patients in a ward or other multiple-bed room, and break down sickroom discipline, if it is not controlled or kept in isolation. The presence of pain in any form offends the senses and sensibilities of any person, sick or well, and especially one who is already debilitated and worried by illness, and located in a neighboring area within earshot, or the hum of inconsiderate gossip. From the one who, in his inability to bear pain, cries out for help, or the one who groans, or bears his yoke comparatively better, there emanates a haunting sense of fear which engulfs all others, if only because it is an ugly reminder of their sickroom environment. Here is an administrative problem of the first order since it cannot be solved at all times by the forces of clinical medicine. No hospital wants to be misjudged by the prevalence of melancholy accents like these.

Pain as a punishment is never justifiable, as any modern penologist will agree, and uncontrollable pain should never be a reason for disciplinary action. You seldom see malingering with the symptom of pain, if only because it is so readily detected. Only the careless observer will accept the word of him who complains and exhibit narcotic relief before doing a thorough physical examination. The law does indeed require this because of the baneful effects of narcotic drugs administered indiscriminately and repeatedly.

The hospital administrator can take the measure of his medical staff by their reaction, for greater or lesser periods of time, to acute symptoms like these. Rewards are waiting, up to and including the reward of immortality, for the physician who carries on till he gets at the root of the difficulty. The doctor who turns away from a patient after the successful, or unsuccessful, administration of narcotic medication may be embarrassed at a later time by another physician whose conscience is more sensitive and more durable and who reaps the rewards of intelligent persistence.

With all of the manifestations of pain, and its related symptoms in their infinite variety to urge him on, the organizer of medical care has his work laid out for him. It is helpful to him to know organizationally how to respond promptly to pain, regardless of rules and regulations, and, whatever the cause, to deal with it totally and not as a limited call for emergency help. There are, in fact, three successive stages in the offer of hospitalization: (a) first aid, (b) cure and (c) rehabilitation. Pain wears off in many cases, having accomplished its diagnostic mission, and this may be spontaneous, the result of medication, sur-

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gical relief, or physiologic adjustment to a bad situation. "The soul of a man should never be tried by those unfortunate things in life to which he can become accustomed," runs an old proverb. Depending on the individual threshold to pain, the sufferer may be able to tolerate it better in the period which succeeds its sudden onset. The most desirable form of resolution for such a symptom after sedation is, of course, the removal of the cause, in which case a recurrence need not be expected. The least desirable is the one in which the cause is beyond human reach by any known medical or surgical device. But, whatever the course of the illness, persistence of the symptom in less acute form does not justify loss of interest on the part of the organizer of medical care. So long as the symptom of pain remains, as the result of a stubborn pathological condition which is in the background, interest must keep pace as well as helpfulness. Continuation of hospital effort seldom fails to provide its rewards if it is not broken prematurely; it is the *sine qua non* of medical research.

The hospital administrator who is sensitive to the demands of pain as a symptom, or as a threat, should have some familiarity with the contribution of pharmacology in general and of anesthesia in particular and draw the proper lessons from them. He must learn to view his problem in greater depth. His response will not only bring temporary relief during a short hospital stay but determine causes with a view toward their removal during a longer stay. Major planning in construction, equipment, organization and administration must be adjusted to the need for radical cures, or attempts at radical cures. The hospital cannot be content with any effort that is directed solely to the removal of this or that sign or symptom of illness, however acute. Having assumed responsibility, the administrator must see it through, if necessary, till he is thwarted by death itself, and he should do all this — or strongly recommend that it be done — not only for the sake of the patient himself but for the sake of those that must surely follow him.

Without the symptom of pain, the acute general hospital would be transformed overnight into an institution which cannot distinguish between "acute" and "chronic." Pain in itself, like its near relatives in the book of symptoms, provides the acute general hospital with justification and excuse at the same time. It creates the possibility of selectivity in the admitting office which may or may not be just. Its continuation in chronic form should be an acute irritant in keeping interest alive in the problem. Lack of space for such a patient is cold comfort to hospital authority when applicants are admitted or rejected according to policies of relative rather than absolute eligibility.

There are, of course, illnesses that do not have the symptom of pain as a major component of the syndrome, and pain may in fact be missing altogether. When this occurs a valuable stimulant to administrative action may be lost, though it may be replaced by other stimuli which are equally urgent from both the social and medical points of view. But the planner of medical care who goes only by the evidence of acuteness in organizing his hospital runs the risk of being misled by it. Incidentally, the relief of pain justifies many a medical fee, but this is by no means the last word in the economics of medical practice.

It is quite reasonable to adjust the

(*Continued on Page* 121)

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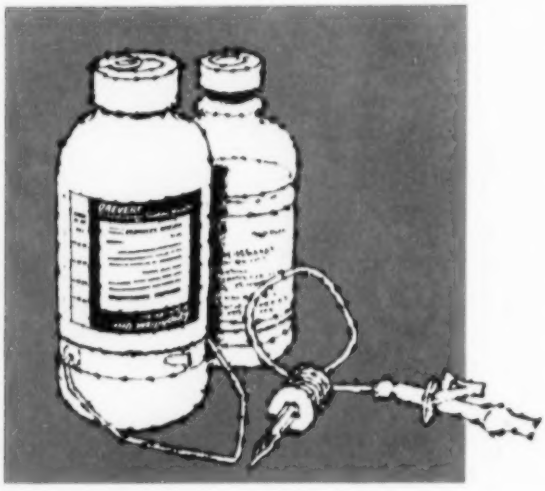

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†Javid, M.: Urea—New Use of an Old Agent, Reduction of Intracranial and Intraocular Pressure, The Surgical Clinics of North America, Philadelphia, W. B. Saunders Company, August, 1958, p. 907.

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(*Continued From Page* 118)

supply of beds to the demand so long as the required facilities are made available to meet the various gradations of greater need while it lasts. But the person in whom acute pain has been dulled through adjustment to adversity, by sacrifice, or otherwise, may be as much in need as his neighbor who is still in the acute stage. His need does, in fact, remain and he requires relief and support to the extent that he has been rendered helpless or disabled. A patient suffering from chronic arthritis, for example, may well be, and usually is, a more poignant if more resigned problem to the science of medicine than the one suffering from acute arthritis. The same may be said for any of the prolonged illnesses. We cannot forget that many "chronic" illnesses are the result of an "acute" opportunity which has been lost! Certain it is that new remedies should constantly be sought for "incurable" as well as "curable" patients. No man would know at what point to draw the line between "acute" and "chronic" in his attempts at a cure, yet many proceed as if they could identify this very point. Premature discharge from a hospital to an unsupervised home, with consequent loss of opportunity, can no longer be justified in this era of hospital-home care. The effort in the laboratories, as well as in the sickroom, must therefore be continuous and unrelenting from the time that responsibility is assumed.

While pain is a guide as well as a stimulant to administrative, clinical and laboratory effort — both socially and medically — it is not exclusively reliable for planning purposes. It must be controlled, if not relieved, and control is only possible when underlying physical, mental and environmental circumstances are allowed to speak their part. This does not commit the hospital to inpatient care during all levels of pain and its allied symptoms; it does commit the hospital to follow through on a responsibility which it has assumed and make its facilities available on a continuing basis, in home and hospital, in youth and age, in "acute" and "chronic" phase of illness. Persistence and tenacity have won many a medical victory. Superficiality and lack of patience have combined to blind us too frequently to the possibilities that still lie ahead. But motivation in human progress is another subject and it is, at times, a painful one! ■

For additional information, use postcard facing Cover 3.

How Drugs Act on Autonomic Ganglia

A review of stimulants and blocking agents and their effects on the autonomic nervous system

THE mediation of nerve impulses through an autonomic ganglion is a multiphasic process. According to present concepts (Perry, 1957) it can be thought of as consisting of seven phases: (1) Conduction of impulses in the myelinated presynaptic fiber; (2) conduction in the presynaptic terminals which are probably nonmyelinated; (3) release of acetylcholine (ACh) at the presynaptic terminals; (4) ACh crossing the synaptic gap, occupying receptors of the cell membrane and being hydrolyzed; (5) local response of postganglionic neuron to ACh; (6) initiation of propagated action potential, and (7) conduction in the postsynaptic axon.

The relation of these phases to the structural elements of a ganglion is represented in the diagram in Figure 1. This schematic figure represents only the ganglionic connection of one preganglionic axon with one nerve cell. Usually one axon terminates on the surface of many cells and a single cell is in contact with the preganglionic endings of many axons. Thus, the ganglion is rather a reticular system of nerve fibers and ganglionic cells. The ratios of the preganglionic to postganglionic nerve fibers are characteristic for the two different divisions of the autonomic nervous system and this ratio is about 1:20 for sympathetic and 1:1 to 1:5 for parasympathetic ganglia.

It is most probable that the nerve impulses are mediated at the ganglionic synapses of the autonomic nervous system by ACh. In this respect autonomic ganglia are similar to other (acetyl) cholinergic receptor sites. A very elegant experimental method used by Kibjakow (1933) and by Feldberg and Gaddum (1934) showed the role of chemical transmission in these ganglia. The superior cervical ganglion of the cat was isolated from the systemic circulation and perfused. ACh could be detected in the perfusate of the eserinized ganglion when the cervical sympathetic trunk was stimulated preganglionically.

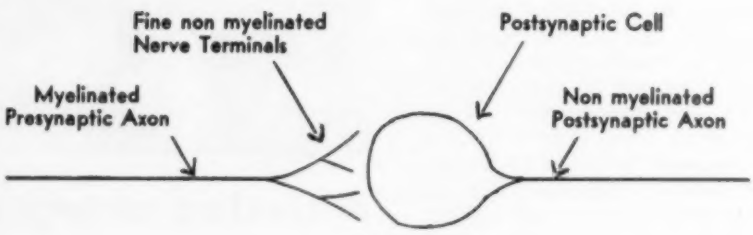
ACh injected into animals under proper conditions stimulates the cells of the parasympathetically innervated organs (smooth muscle, glands, heart), and can produce stimulation and secondary block of (1) ganglionic transmission, (2) end plates of striated muscle, (3) some sensory endings.

The interaction of ACh with the receptor substance of the ganglionic nerve cells leads to a transient depolarization. Larger doses produce persistent depolarization. Thus, ACh has a dual effect on the ganglion, stimulating in small and blocking in large doses. This dual effect is also observed at the neuromuscular junction, while at the postganglionic parasympathetic effector sites ACh has only a stimulatory action.

There are other compounds which stimulate autonomic ganglia. Some of these act more selectively at these ganglia than ACh leaving the other cholinergic effector sites unaffected. These agents stimulate the ganglia of both divisions of the autonomic nervous system; thus, symptoms of the hyperactivity of both sympathetic and parasympathetic systems can be observed. It is a characteristic of all ganglionic stimulants that they have, as ACh has, dual effects – stimulation after smaller doses and blockade after larger ones.

The cardiovascular effects of ganglionic stimulants are complex; the heart rate may be slowed by vagal

Fig. 1
Diagrammatic Representation of Ganglionic Synapse



Phases of Transmission*

1 2 3 4 5 6 7

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excitation, which is usually followed by an increase of the cardiac rate caused by sympathetic stimulation. The blood pressure increases considerably as the result of the widespread discharge of the sympathetic ganglia (which are predominant in the vascular system). The stimulation of the adrenal medulla results in the output of epinephrine and nor-epinephrine which may be partly responsible for the cardiac effects and for the blood pressure increase. (The adrenal medulla is embryologically related to sympathetic ganglion cells.) Stimulation of the carotid and aortic body chemoreceptors by these agents strongly influences the cardiovascular and respiratory reflex mechanisms.

Ganglionic stimulants also produce transient miosis which is followed by mydriasis. The tone and the movements of the gut and of other smooth muscle organs generally increase. Secretions of exocrine glands are also stimulated by the increased parasympathetic discharges.

The best known ganglionic stimulant is nicotine, an alkaloid of tobacco leaves. It differs from ACh in that it does not stimulate the parasmypathetic effector cells; its stimulant actions are confined to the autonomic ganglia, to motor end plates, and to some sensory endings. In toxic doses blockade of the autonomic ganglia occurs in addition to tremors and convulsions of central origin. Nicotine is not used in therapy but has theoretical and historical significance. Pharmacologists have been interested for several decades in nicotine as an important tool for examining the function of autonomic ganglia. At the end of the last century Langley (1889), using the ganglionic blocking action of nicotine, explored the localization of autonomic nerves in ganglia and some basic physiological characteristics of these synaptic connections.

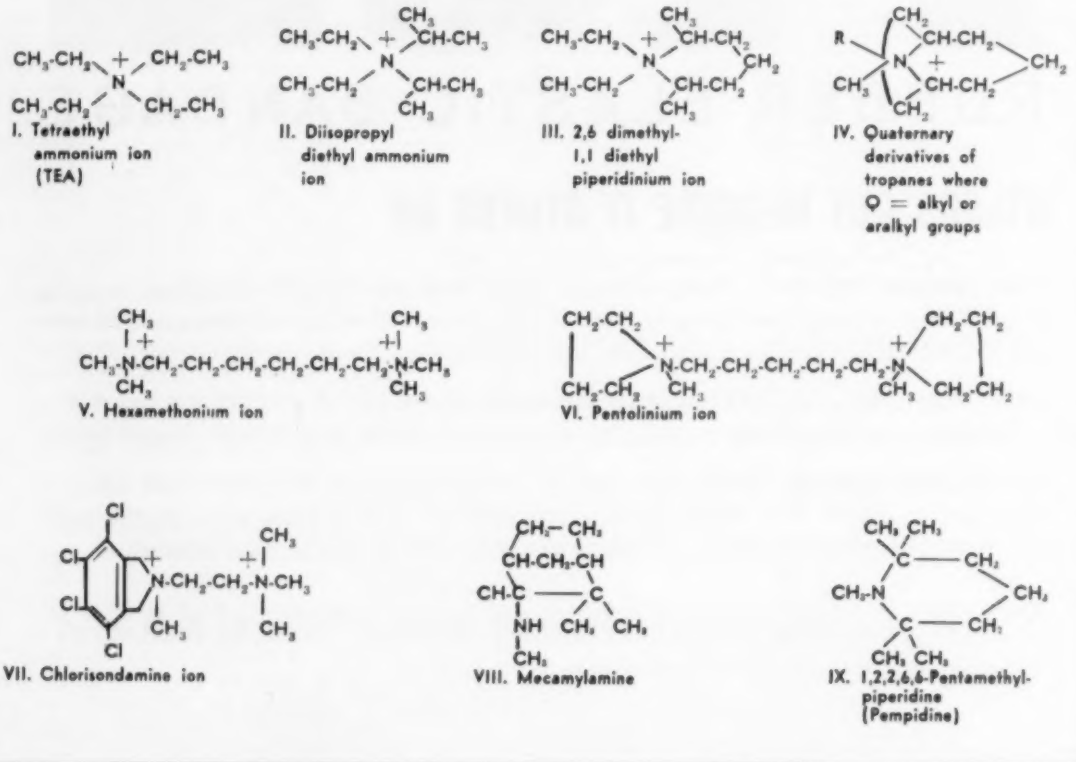
Lobeline, an alkaloid, obtained from Lobelia inflata has quite similar pharmacological properties. Its stimulant action on the chemoreceptors has been used for the treatment of apnea of the newborn.

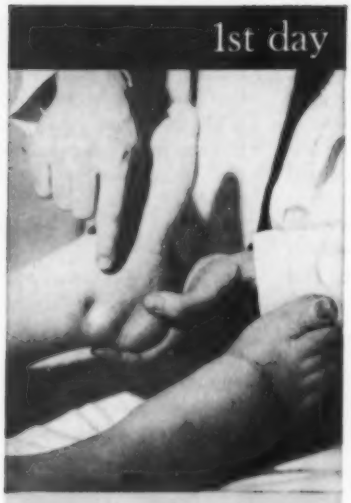
The manifold other, not purely ganglionic, stimulant actions of nicotine initiated investigations on ganglionic stimulants which act more selectively than nicotine. Most other ganglionic stimulants are quaternary ammonium compounds which have not found any use in therapy: Tetramethylammonium ion has a strong stimulant and only weak blocking action on autonomic ganglia, and in addition, it stimulates postganglionic parasympathetic effector sites. Choline phenyl ether (Hey, 1952) and dimethyl-phenyl-piperazinium (DMPP) (Chen et al., 1951) are more selective ganglionic stimulants; however, they are not devoid of some blocking properties. The most potent ganglionic stimulant hitherto known is a tropine derivative, p - phenylbenzyl - p - aminobenzoyl - tropinium bromide, which also has strong ganglionic blocking properties (Gyermek and Nador, 1955).

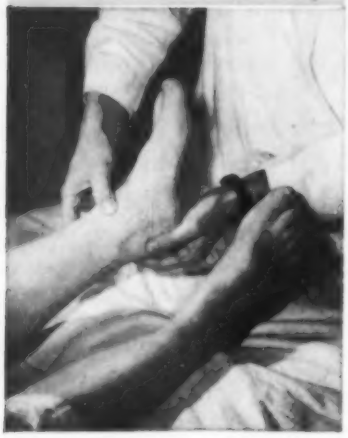
Blockade of Autonomic Ganglia

In contrast to ganglionic stimulants, all of which have dual effects, *i.e.* a

Fig. 2 ***Chemical Structures of Different Ganglionic Blocking Drugs***

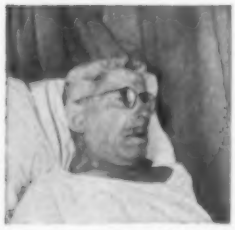






Record of patient with congestive failure treated at a leading Philadelphia hospital. Photos used with permission of the patient.

marked pitting edema (4+) cleared in 4 days with Esidrix.



L.S., 81 years old, admitted to hospital 3/3/59 with hematuria, arteriosclerotic cardiovascular disease, poorly compensated heart failure. When 4+ pitting edema, hepatic congestion and râles failed to clear on regimen of salt restriction, digitalis and pulmonary decongestants by 3/6, Esidrix 50 mg. b.i.d. was ordered. By 3/8 L.S. had lost 3 pounds, pitting edema was reduced to 1+, râles decreased. Patient was ambulatory on 4th day of Esidrix therapy; no evidence of edema. He was discharged feeling well on 3/14.

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stimulation followed by blockade, ganglionic blocking agents block autonomic ganglia without any preceding excitatory phase. Most of these agents act predominantly at the autonomic ganglion cells and have little influence at other receptor sites; thus they have a relatively high degree of selectivity as to the site of their action. The mechanism of cholinergic neurotransmission at autonomic ganglia and at neuromuscular junctions is somewhat similar, and agents acting at either of these sites are not absolutely specific. Tubocurarine and most of the synthetic curare-like agents also depress autonomic ganglia. Conversely, ganglionic blocking agents in very large doses may produce some degree of neuromuscular blockade.

The inhibition of transmission through autonomic ganglia produced by most of the commonly used ganglionic blocking agents is due to a competition with the ACh which is liberated at the endings of the preganglionic nerves. Therefore, the combination of ACh with the synaptic receptor sites is impaired, while the formation of ACh is not influenced. This type of blockade can be overcome by an excess of ACh, *e.g.* cholinesterase inhibitors, which inhibit the breakdown of ACh, are able to counteract ganglionic blockade produced by competitive blocking agents. This competitive type of inhibition is similar to that produced by tubocurarine, gallamine and other curare-like agents at the neuromuscular junction. (Another type of cholinergic blockade is characterized by a persistent depolarization of the ganglion cells or motor end plates.

This type of blockade can be obtained at the ganglia only with compounds like nicotine which stimulate first and block afterwards. The neuromuscular blocking agents, succinylcholine, decamethonium and, in excessive doses, ACh, act by this mechanism at the motor end plates. This blockade is not antagonized but intensified by the addition of ACh or anticholinesterases.)

Ganglionic blocking agents are substituted ammonium compounds or ionizable secondary or tertiary amines; all of the known agents have been produced synthetically. A possible explanation of their action (at least in the case of the quaternary ammonium compounds) is the competition between the blocking agent and the trimethylammonium "cationic head" of ACh for the ganglionic receptor sites. The simplest examples of this class are the tetra*ethyl*ammonium salts which were the first ganglionic blocking agents to be used therapeutically. In these compounds *ethyl* groups replace the *methyl* radicals present in the cationic group of ACh or tetra*methyl*ammonium ion; the methyl groups are responsible for the stimulatory effects.

Other important ganglionic blocking agents like hexamethonium, pentolinium (Paton and Zaimis, 1952) (Smith and Hoobler, 1956) and chlorisondamine (Plummer et al., 1955; Smirk and Hamilton, 1956) have two trimethylammonium or similar cationic groups which are separated by a variable number of methylene ($-CH_2-$) groups. These connecting chains, and the presence of a second similar cationic group at a given intramolecular distance from the first, are probably responsible for the blocking action of shielding against the "invading" cationic group of ganglionic stimulant.

An "umbrella-like" molecular structure present in the atropine molecule

For additional information, use postcard facing Cover 3.

which is of importance in the ACh-atropine antagonism (Pfeiffer, 1948) might also have significance in the interaction of the ganglionic blocking and stimulant drugs. The diisopropyl diethylammonium ion, 2,6 dimethyl 1, 1 diethylpiperidinium ion (Winbury, 1952), and quaternary ammonium derivatives of tropane compounds (Gyermek and Nador, 1957) have branching carbon chains (indicated by heavy lines in Figure 2) around the N atom and are highly active ganglion blocking agents. The newest and clinically most potent secondary and tertiary amine derivatives such as mecamylamine (Stone et al., 1956) and pempidine (Corne and Edge, 1958) also have similar structural features which would be capable of producing a shielding effect against the trimethylammonium cationic group of ACh.

The action of ganglionic blocking agents is usually manifested in a blockade of both sympathetic and parasympathetic ganglia as might be expected from their structural and functional similarities. It is desired for therapeutic purposes that the overactivity of only one division of the autonomic nervous system or of one organ would be specifically diminished by ganglionic blockade without much influence on the normal functions of the other parts of the autonomic nervous system. This can hardly be achieved because, as mentioned before, ganglionic blockade means usually a widespread (*i.e.* nonselective) diminution or block of transmission of all ganglia. The signs of ganglionic blockade are, on the other hand, dependent in different organs upon the functional proportion of sympathetic and parasympathetic innervation.

Since the parasympathetic nervous system is functionally predominant on secretory glands and on the intestine, ganglionic blocking agents produce a diminution of parasympathetic tone. Dryness of the mouth, inhibition of gastric secretion and of sweating are common after inducing ganglionic blockade. In the gastrointestinal tract, the interruption of the parasympathetic motor tone is apparent. Dilatation of the stomach and decreased motility of the small intestines and colon lengthen the emptying time; thus larger doses of long-acting ganglionic blocking agents may produce constipation, flatulence and sometimes even symptoms of paralytic ileus. In these organs ganglionic block resembles the action of atropine. (Atropine, however, exerts its inhibitory effect postganglionically at the parasympathetic effector sites.) The parasympathetic motor innervation of the urinary bladder is also blocked by ganglionic blockade and may induce urinary retention.

In the eye, ganglionic blocking agents produce mydriasis by blocking the tonic parasympathetic discharge reaching the constrictor muscles of the iris. The site of action is at the ciliary ganglion. By blocking the impulses to the ciliary body, ganglionic blocking agents also limit the ability to focus on near objects.

The influence of ganglionic blockade on the cardiovascular system is fairly complex. Several factors are involved. Most important is the temporary interruption of the sympathetic outflow to the vasomotor nerves at the ganglionic level which is manifested in a blood pressure fall, especially when an individual is in an erect position (postural hypotension) when the cardiac venous return is also impaired.

Ganglionic blocking agents influence cardiovascular reflex mechanisms by acting at the efferent and to a

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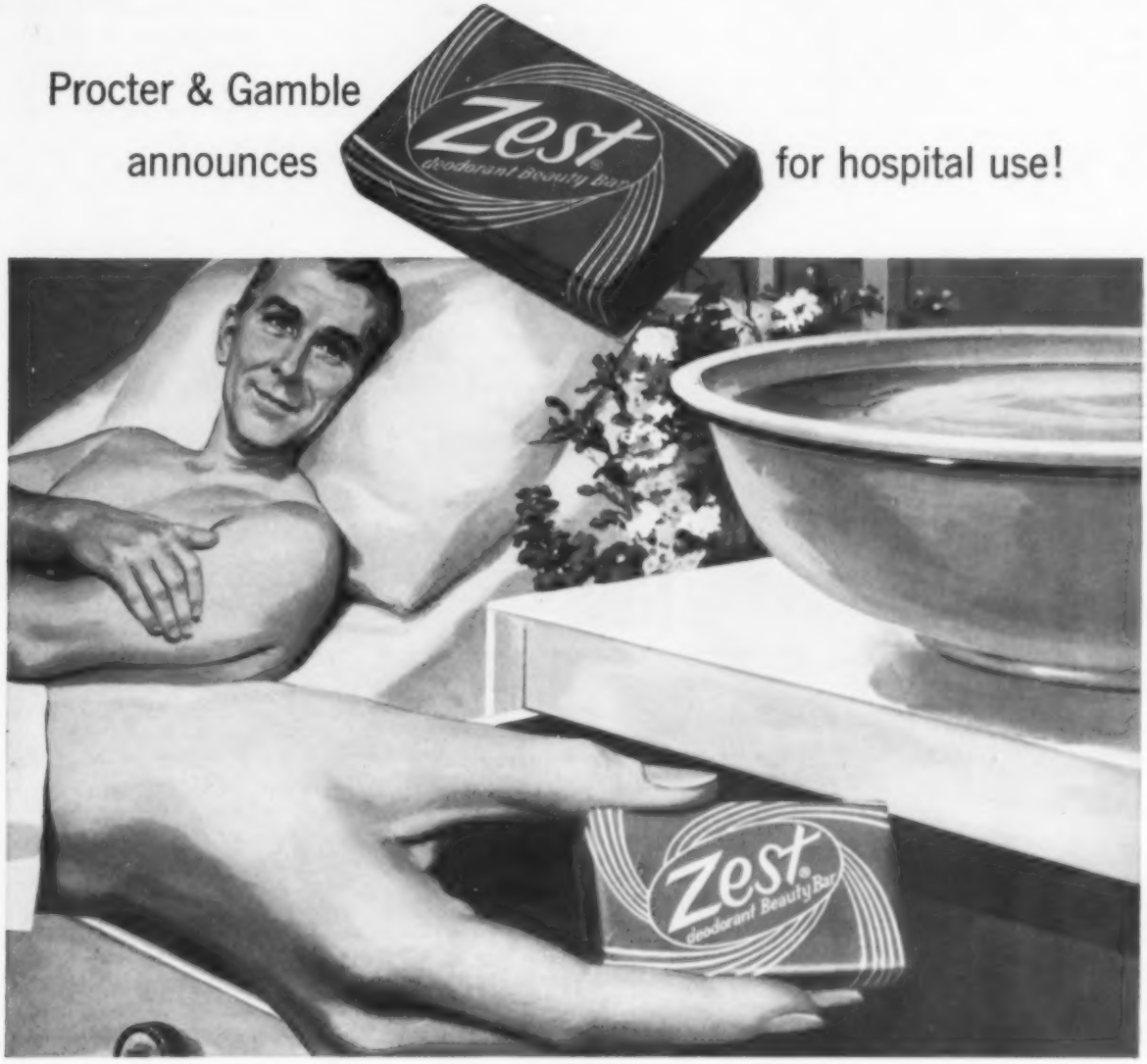

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lesser degree at the afferent portion of the reflex arc. By blocking autonomic ganglia and the carotid and aortic chemoreceptors they prevent experimentally induced blood pressure rises elicited by clamping the carotids, Valsalva maneuver, or cold pressor test. On the other hand failure of compensatory reflexes results in an enhancement of the effects of such vasoconstrictors as epinephrine, angiotonin, and so forth, and also of vasodilators. A marked fall in blood pressure may impair renal function, an important factor to be considered in hypertensive patients and during controlled hypotension in surgery.

Apart from the pharmacologically established side effects of ganglionic blocking agents (muscular weakness, neuromuscular paralysis caused by very large doses, possible blockade of nerve conduction by nonquaternary type of ganglionic blocking agents, *e.g.* mecamylamine) a widespread and intensive blockade of the ganglia per se, caused by overdosage, might be harmful. A marked and abrupt blood pressure fall (orthostatic hypotension or collapse) may occur. Since ganglionic blockade leaves the postganglionic effector sites unaffected, sympathomimetic amines: nor-epinephrine, neo-synephrine or ephedrine which act at the postganglionic sympathetic sites can effectively raise the blood pressure to a desired level. Another important untoward effect resulting from overdosage is the paralysis of intestinal movements. Compounds acting directly on the bowel (laxatives) or anticholinesterases like neostigmine (by counteracting the competitive type of ganglionic blockade) are able to reduce the inhibition of intestinal motility.

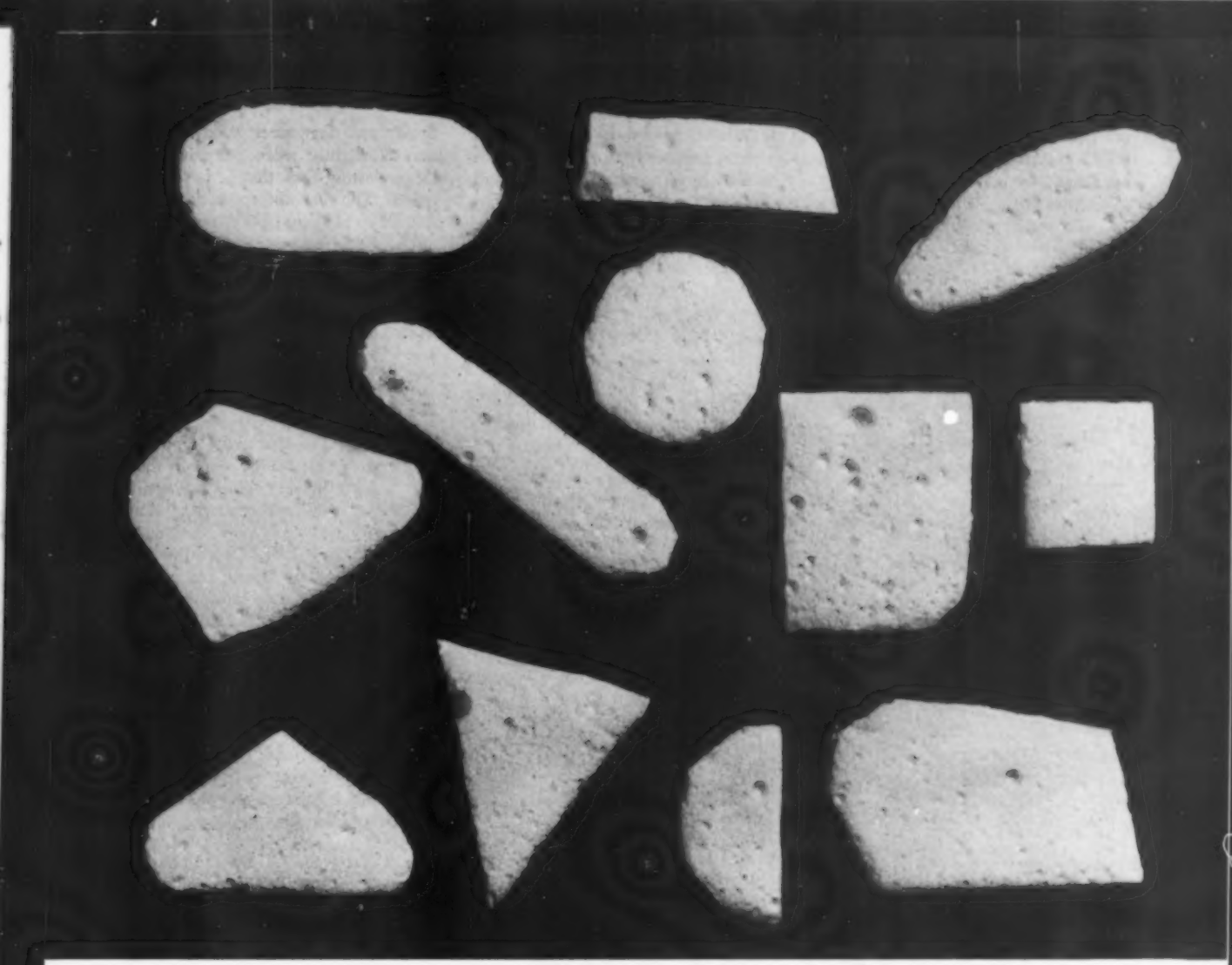
Preparations

The commercially available ganglionic blocking agents are markedly different in potency, onset, duration of action, and in their oral absorption. These variables and possible side effects are the most important factors in choosing the suitable agent for therapeutic purposes.

Tetraethylammonium (TEA). It is the oldest ganglionic blocking agent. Its pharmacological properties were first described by Burn and Dale (1915) but a detailed reinvestigation was carried out by Acheson and Moe (1945). Because its effect is short-lasting, the injections should be repeated several times a day. The intravenous dose is 0.2-0.5 mg./kg. body weight; much larger doses up to 10 mg./kg. may be administered intramuscularly. The elimination of the drug by the kidneys is very rapid; 50 per cent of the intravenous dose is present in the urine 30 minutes after injection. Provided renal function is normal, half of the intramuscular dose is excreted within four hours. The elimination proceeds through glomerular filtration and tubular excretion. TEA is so poorly absorbed from the gastrointestinal tract that it is administered exclusively by the intravenous or intramuscular route.

Other monoquaternary ammonium derivatives, some more active than TEA, are not used in therapy because of their relatively short duration of action.

The newer ganglionic blocking agents usually have a slower onset and a longer duration of action; and some of them are much better absorbed from the gastrointestinal tract than TEA. Bis-ammonium compounds containing two quaternary nitrogen groups deserve special attention. Compounds in which the two N atoms



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are linked by a straight chain of 5 or 6 CH_2 groups are ganglionic blocking agents and are almost devoid of blocking action at the neuromuscular junction. In contrast, bis-ammonium compounds having longer connecting chains (*i.e.* 9-10 C atoms) between the two trimethylammonium groups are blocking agents of the neuromuscular junctions (*i.e.* Decamethonium). The hexamethonium salts (Bistrium, Esomid, Hexamethon, Methium) are about 10 times more effective than TEA on a weight basis and have a longer-lasting action. Several years of clinical experience have shown the value of hexamethonium in the treatment of hypertension. The poor and irregular absorption of oral doses represents a drawback involving the necessity of massive doses amounting to 1-2 g. per day. Preference has been shown for chloride salts of hexamethonium on account of the side effects of bromism and iodism occurring after the prolonged administration of bromide and iodide salts.

Pentolinium (Ansolysen) which is available in the tartrate salt form is similar to hexamethonium both structurally and pharmacologically. Its action is slightly more intensive and longer lasting than that of hexamethonium. The oral absorption is better, thus doses of about 60-300 mg. per day might be given orally. Chlorisondamine (Ecolid), mecamylamine (Inversine) and pempidine are the newest of ganglionic blocking agents. All of them are extremely potent and have a slow onset and long duration of action. They are given orally in doses of about 100 mg. (Chlorisondamine), or 5 to 10 mg. (mecamylamine), (pempidine) daily. The last two compounds represent a new achievement in therapy with ganglionic blocking agents since they are not quaternary ammonium compounds and are consequently well absorbed from the gastrointestinal tract. Both compounds are, relatively new; thus, extensive clinical evaluation is not yet available.

Elements other than N, like S, As and P are capable of forming compounds with a cationic character similar to the ammonium cation. Of these a sulphonium compound, trimethaphane (Arfonad) (Randall et al., 1949) is available as a short-acting ganglionic blocking agent suitable for obtaining controlled hypotension during surgery.

Therapeutic Applications

Three major effects of the ganglionic blocking agents are useful in therapy: (1) Decrease of the tone of the vascular sympathetic innervation resulting in hypotension; (2) decrease of the parasympathetic impulses going to the gastrointestinal tract manifested in block of motility and secretions, and (3) decrease of pain from visceral organs. Accordingly, ganglionic blocking agents were introduced for the treatment of hypertension and peripheral vascular diseases, and of diseases of the gastrointestinal tract.

The main use of ganglionic blocking agents is in the treatment of hypertension. The effect of these agents may vary according to the type of the hypertensive disease, for example, in hypertensive encephalopathy the fall of blood pressure is very pronounced while in cases associated with kidney malfunction the blood pressure change may be insignificant, and in pheochromocytoma even a blood pressure rise may occur.

Usually the benign form of essential hypertension responds best to treatment with ganglionic blocking agents.

(*Continued on Page* 134)

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The effect is dependent upon the type of drug and mode of its administration. TEA salts given intravenously cause rapid, short-lasting reaction, mecamylamine or chlorisondamine orally may produce very sustained, gradual decrease of blood pressure. One must also consider that tolerance to the blood pressure lowering effect of ganglionic blocking drugs may occur. If such an adaptation of the organism develops, interruption of ganglionic blocking therapy may lead to dangerous overactivity of vascular reflexes. Therefore, a gradual withdrawal of the drug will be indicated.

Despite these disadvantages ganglionic blocking agents are of much value in lowering blood pressure in critical conditions associated with extremely high blood pressure. Patients with encephalopathy, congestive heart failure owing to hypertension, acute pulmonary edema, or edema of the retina can be successfully treated with fast-acting ganglionic blocking agents by intravenous injection. After the acute danger has passed, the medication should be continued with slower-acting agents, either alone or in combination with other hypotensive agents: Rauwolfia, veratrum alkaloids, hydralazine, thiocyanate and so on.

Ganglionic blocking agents are also used in the functional disorders of the gastrointestinal tract. Symptoms of peptic and duodenal ulcers can be alleviated by temporary vagal blockade. Since an effective blockade of parasympathetic impulses can be achieved by atropine-like drugs, ganglionic blocking agents are relatively rarely used for this purpose. Results of animal experiments and clinical studies have shown that combination of the postganglionic parasympathetic blockade with a ganglionic one might be of superior value. Thus compounds having both atropine-like and ganglionic blocking properties are of interest in this respect. The methyl quaternary derivatives of atropine and of homatropine (Novatrine), oxyphenonium, methantheline, and propantheline have strong atropine-like and weak ganglionic blocking actions. Two recently investigated compounds, the octyl and p-phenylbenzyl quaternary derivatives of atropine (both marketed in Europe) (Engelhardt and Wick, 1957; Gyermek and Nador, 1957) seem to unite these two types of blockade in a useful proportion and thus merit further attention of pharmacologists and clinicians.—L. GYERMEK, M.D., *Department of Pharmacology, University of Illinois College of Medicine.* ■

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Operating Room Forum

Nothing Can Be Taken for Granted In Combating Infection Problem

By Frances Ginsberg, R.N.


Frances Ginsberg

THE subject of staphylococcal infections brings many hospital people to a state of panic. "Panic," as defined by Webster, is an action often impelled by groundless fear. Although a high incidence of infections gives basis for fear, in combating it hospital people should not revert to panic, but rather to a cold calculating study of the problem and a systematic attack on it.

A sound examination of practices throughout the hospital will often help control, if not limit, all types of infections. This same approach is equally effective in the operating room, but often is divorced in a limited way from the constant suspect, the personnel.

It is true that inefficiency on the part of the operating room personnel will dangerously increase the organism count. This can be, and often is, controlled by certain attentions to human failings. However, those things individuals take for granted many times cause more trouble than the humans themselves.

An example of one such factor is the simple technic, often done in a perfunctory manner, of preparation of the patient's skin for the operation. "Once over lightly"may be the policy, but "once over lightly" can be a "welcome" sign for organisms. Unless there is adequate mechanical friction to remove gross dirt and to defat the patient's skin, other precautions, no matter how carefully carried out, cannot be relied upon to remove organisms or prevent their entrance into the wounds. Such a procedure should begin with a good hexachlorophene soap followed by compatible antiseptics carefully chosen by the infection committee and standardized by the same committee. Deviations from skin preparation standards exert a demoralizing influence on the surgical staff and may well result in direct dangers to the patient.

Draping the patient is another exacting technic often disregarded in its relation to infection. Draping should be done adequately with regard to the thickness of the materials used, and with regard to the methods utilized in handling the drapes, with every consideration for proper sterile technic taken into account.

Another consideration sometimes overlooked or not done in what might be considered accepted methods is that of bacteriologic controls to validate sterilization processes. As a preliminary step it is necessary to restrict the size and contents of bundles, to wrap articles loosely in acceptable coverings, and to load supplies into the autoclave without crowding. Using test organisms whose population and resistance is known, bacteriological studies should be done at least once or twice a month to ensure the efficiency of the sterilizing apparatus. Distinguishing markers, *i.e.* dates, color change tape, or color change ink should be used to differentiate goods that have been through the sterilization process from unsterile goods.

Another system that constitutes an invitation to invading organisms is the long established master table technic. Unless a system of individual setups of sterile instruments and materials is made available for each procedure, hospitals flirt with danger. ■

You just tear this new
foil suture packet open
to give your surgeons stronger,
more pliable surgical gut.
It's sterilized by electron beam.

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Reward of Good Training Is Good Workers

A university hospital that has developed its own training program and manual demonstrates by actual dollar savings that well trained employes who know what they are doing, and why, are happier, stay longer, and are more productive

Peggy S. Stanfield

THE training program for food service employes at the University of Texas Medical Branch, Galveston, in 1958 realized savings of $21,820 in labor costs and $95,586.15 in food costs. These savings have been returned, in part, to the employes in terms of merit raises; furthermore, they have enabled us to serve a higher quality of food to our patients and staff.

Figures like these alone constitute an impressive argument for instituting a training program, but there is a still stronger argument: Unless the people who do the job and make the establishment run have been well trained, neither they nor their employer is happy and the organization will suffer. Almost every organization has realized this need now and many have done something about it.

One of the last to adopt a suitable training schedule has been the dietary department in hospitals. There are many reasons for this: lack of time, caused by the rapid labor turnover (60 per cent per year – the high cost of labor turnover adds an extra $1,666,666 to the cost of hospital management per year) which plagues most dietary departments, lack of money to carry new employes on the payroll until they know their job, lack of teaching manuals, lack of trained personnel to do the teaching, mismanagement and low morale.

Provision for a training schedule and money for this are essential in order to save money in the end and have a happy department. The untrained individual who is hired, and immediately put to work – on a catch as catch can basis by observing someone else doing the job – is likely to become a poor employe, if indeed, he stays at all. So much remains unexplained to him by the person he is watching unless that person himself has been taught to tell others the how and the why of the job. The employe who does a good job does not necessarily make a good teacher. If by chance he has learned skills on his own, he probably will not be able to explain why he does a task in a certain way, except that perhaps it's easier that way for him. While on-the-job training is very necessary, it should be done only by those qualified. "Those qualified" does not mean that a good employe already doing the job would not be eligible; it simply means that if he is to be the one to teach, then he needs "teacher training" before he starts so that he can put the correct technics and skills across to the person he is teaching.

So, then, the training program falls into two main categories: the training of those individuals who will train others, and the actual training of the new employe. Before either can be started, a training manual should be set up for each. The objectives and proper attitudes should be set down for the whole training program, outlining in brief what should be accomplished and the order in which it will be presented. Each hospital department varies in its own particular situation, but the general picture is the same.

Emphasis in all manuals of training should be on the proper attitude toward patients, good hospital conduct and ethics, and these ideas should be instilled in each new employe before he begins to train for his own particular job. When he realizes the importance of his job to others, and his own importance in the scheme of things, then his first positive step has been taken toward becoming a good employe. It has been said that job security means much more than wages to an employe. This is one means of offering him that security.

Those people who usually train new employes will probably be su-

Peggy S. Stanfield is chief administrative dietitian at the University of Texas Medical Branch, Galveston. She received a bachelor of science degree from Alabama College and has done graduate work at the University of Tennessee. Miss Stanfield was on the dietary staff at Baroness Erlanger Hospital, Chattanooga, Tenn., for seven years, four as assistant executive dietitian, and on the dietary staff at Orange Memorial Hospital, Orlando, Fla.

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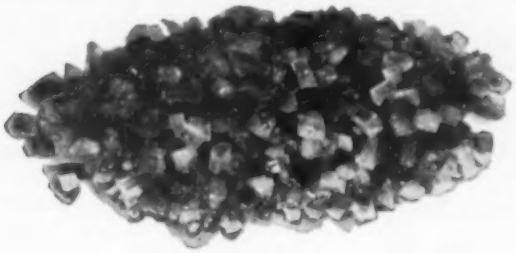
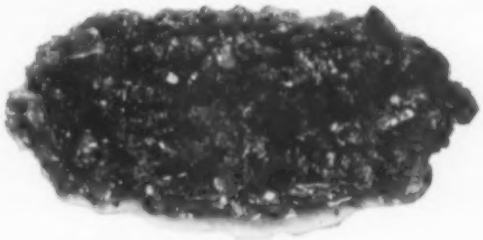
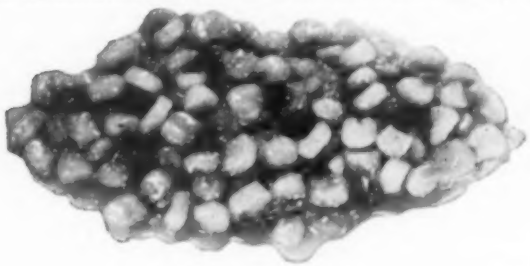
Sweet Cucumber Circles



Sweet Relish (COARSE CUT)



Sweet Pepper Relish



Corn Relish

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Tiny Sweet

Sweet Mixed

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Sexton *Quality Foods*

The white lines indicate the hand motions required to roll and crimp a pie crust: nine to 12 strokes with rolling pin and 28 pinches with thumb.

pervisors in the different areas of the dietary department. They should be selected not only for their efficiency but for their personalities and their ability to put a point across. After having determined who these people are, classes should be held for them so that when they start to train others it will be obvious that they can do it well, and that they also feel secure in their knowledge. These people should be taught the fundamentals of time and motion, so that when they teach new employes they can set up standard motions (by the number of strokes, or motions taken, and the time involved) which the new employe can easily understand and use to reduce unproductive effort and finish work more rapidly. For example, the trainer should be able to tell and demonstrate how to roll a pie crust with 9 to 12 strokes, at 45° angles from the body. The new employe will be able to appreciate and use this information. (The photograph accompanying this article is an illustration of practical uses of such studies.)

Another phase of training which is most important is that of portion control. The supervisor should be able to tell at a glance if the size of portions are correct, and the worker should also have sufficient training to be able to *serve* the correct size portion consistently. Many dollars can be saved annually with a tight control on portions. This applies to the patients' food, the cafeteria food, and to the food the employe receives as well, if meals are furnished.

The persons chosen for the training job must have a genuine interest in others, the ability to put them at ease, the tact necessary to provide a basis for constructive criticism when it is necessary, patience and a sense of humor. Without this type of personality the training program will not succeed.

Much has been said about the actual training of a new employe and much literature on the subject is available. Judging from its own particular needs, the hospital will be able to pick out the type and kind of training program suitable for its own situation and get it into operation once the personnel to do the training has been selected and is ready to begin. All material used should be set up in a manual for the trainees and this manual should be given them to use as a future guide and reference. (See accompanying article.) It need not be expensive, but should contain all the necessary information. The information found in training manuals is generally based on these points:

1. Hospital ethics and conduct.
2. Hospital policies affecting the employe vacations, holidays, meals, pay periods, and grounds for dismissal.
3. Hospital benefits which he will receive such as insurance, sick leave, physical examinations and workman's compensation, if any.
4. Safety measures.
5. Sanitation. Maintenance of strict

University of Texas Food Service Manual Spells Out Policies and Procedures

A FOOD service workers handbook, presented to all employes, is an innovation of the dietary department, University of Texas Medical Branch Hospitals.

Among the general policies are:

Each employe is given a permanent badge that must be worn at all times with the number visible.

To be paid, each employe must punch a time card at the beginning and end of each work day. Any error or overtime must be initialed by a supervisor or time clerk.

Each employe must check with the main kitchen supervisor when arriving at work each day. When he must be absent from work he is expected to notify the kitchen office at least 30 minutes before he is due to punch in. Anyone who is absent from work because of illness must furnish written proof from a doctor. A record is kept for each employe. Three absences without a valid excuse are considered reason for discharge.

The manual gives complete details on pay deductions, vacations — employes must work six months before they are eligible for vacation — and medical examinations. Every six months employes must have a food handlers examination which the university gives without charge.

Explicit details cover: injuries (which must be reported immediately to the supervisor and a blue slip obtained to go through the emergency room), meals furnished (15 minutes allowed per meal), uniforms and working shifts.

Weekly schedules are posted in the main kitchen. Daily schedules must

(*Continued on Page* 144)

there's no juice like citrus *juice*

As a high-potency source of vitamin C, citrus juice—fresh, frozen, or canned—is unmatched for convenience and economy. The table below shows amounts† of other fruit juices required to supply the 100 mg.* of vitamin C in one glass (7-9 fl. oz.) of citrus juice.

citrus	1 glass
apple	50 glasses
grape	9 glasses
pineapple	3-4 glasses
prune	50 glasses

†Data calculated from: Watt, B. K. et al., U.S. Dept. Agric. Handbook No. 8, 1950; and Burger, M. et al. Agr. & Food Chem. 4:418, 1956.

*This is the peak of the Recommended Daily Allowances for adolescence or pregnancy; 150 mg. during lactation; 70-75 mg. for normal adults.

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TANGERINES

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sanitation practices in order to pass rigid inspections that combat the staphylococci and other infections prevalent in hospitals.

6. Personal hygiene and proper eating habits.

The specific information in a training manual usually follows these lines:

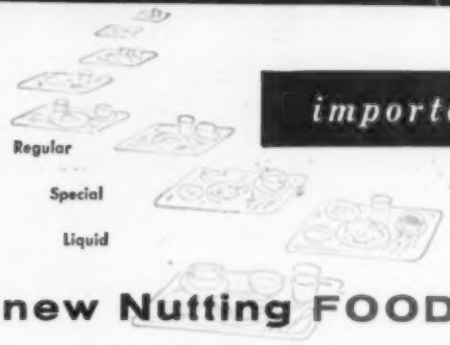
1. Job descriptions.
2. Chain of command.
3. Relation of the areas within the department and relation of the department to other departments.
4. Department regulations (more specific than general hospital rules) such as routine six-month physical examinations, food handlers certificates, inventory times, issuing of supplies, meal hours, and so on.
5. Proper procedures for all technics, such as dishwashing, mopping and use of equipment.
6. Some information on time and motion, enabling the employe to gain more speed and lighten his work load.

Little has been said about the retraining of old employes and this, as any dietitian will tell you, is often the hardest part of any training program. To teach new methods and to change procedures which they have followed for years, in such a way as not to ruin the employes' feeling of security and still succeed in establishing and maintaining new and better technics, is indeed a major triumph. It can and must be accomplished in order to operate a department properly and save time and money. We have found, through experience with our own employes, that the following methods served us best:

1. Regular meetings with all the dietary personnel, explaining fully why changes were being made and how they would affect each of them.
2. Regular classes with small groups (each area) and with more detailed, yet simple, explanations.
3. Demonstrations, lectures, visual aids, and simple steps of time and motion for all technics to be altered.
4. Regular meetings with all supervisory employes, informing them of our intentions, and inviting their comments and suggestions to help push the program across.
5. Firm adherence to the principles or new patterns to be put into use, by constant supervision until the new becomes the accepted pattern for all concerned.
6. Constant alertness to maintain what was accomplished so that no one slips back into the old methods.
7. Regular assemblies once a week with both supervisors and workers for discussion of problems and morale boosting.
8. Mimeographed instructions posted liberally on bulletin boards for reference whenever necessary.
9. Distribution of copies of the training manual to all employes.
10. Follow-up on all procedures, so that the employe knows that his work is being evaluated.

It would seem, then, that most of the working day is spent with training – and so it is. Whether consciously or unconsciously, we train all the time – by example, by word, by demonstration, by formal instruction. This is why the training program is the core of the successful dietary department. Since so many man-hours are put into the program, it is essential that the work be successful. Success will show in the department in two main ways: in a smooth operation with happy people doing a good job and a concrete saving in money, for the sucessful training program cuts down man-hours and waste and speeds up production and efficiency. ■

important FOOD SERVICE news

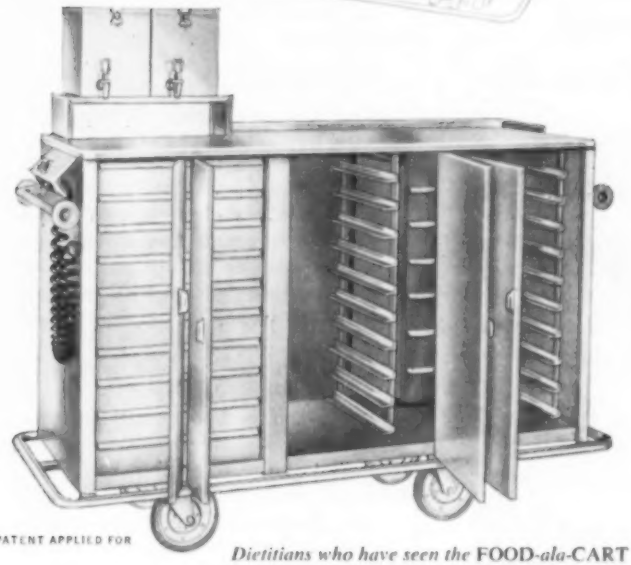


The all new Nutting FOOD-*ala*-CART System

ends "DIET TRAY CONFUSION!"

Here for the first time is a food service system that ends one of the biggest problems facing dietitians . . . "Diet Tray Confusion." FOOD-*ala*-CART is the first and only food service system to provide *one oven drawer* for *every serving tray!*

This exclusive FOOD-*ala*-CART feature ends "Diet Tray Confusion" and makes spot checking easier — more accurate. It also speeds tray assembly — makes it simpler.



PATENT APPLIED FOR

Dietitians who have seen the FOOD-*ala*-CART system say it's the easiest to use equipment they have ever seen. Its design is based on a comprehensive research study among dietitians. These dietitians told us it's not the fixing of the food but the serving that is the big problem. The Nutting FOOD-*ala*-CART answers the serving problem best because it simplifies it, ends "diet tray confusion," keeps foods appetizing, refreshing, delicious tasting right to the patient. It is truly *the new standard of fine food service for hospitals.*

Only the new FOOD-*ala*-CART system offers *all* these features!

- ONE OVEN DRAWER FOR EVERY SERVING TRAY ends "diet tray confusion." It's the easiest to use food service system you have ever seen.
- FROZEN FOOD SECTION keeps frozen desserts served in sliced form, in ramekins or similar containers frozen; even ice cubes won't melt.
- ALL FOODS are served at dietetically accepted temperatures for maximum patient "meal appeal."
- VERSATILE INTERIOR — Easily changed to accommodate 3 different tray sizes; no tools are needed. Can also be changed to handle from 16 to 24 trays. Interior can be easily and entirely cleared for steam cleaning.
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- COMPACT SIZE makes FOOD-ala-CART easier to handle. Clears any hall, door or elevator opening.
- SAFER — Center hung door panels do not extend beyond cart when open.
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Everyone is happier with FOOD-*ala*-CART! Patients, physicians, nurses, aids *and* dietitians, *all* like the way FOOD-*ala*-CART eases preparation, keeps foods appetizing and simplifies serving.

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Name_____

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Address_____

City_____ State_____

(*Continued From Page 140*)

be checked with a pencil or the employe is considered absent.

Under the heading of personal health and hygiene, the manual asks: "Do you:

"1. Get enough rest? The average adult needs eight hours sleep before each working day.

"2. Eat a balanced diet?

"3. Wear a coat in refrigerated areas?

"4. Have good posture?

"5. Report any cuts, sores, boils or respiratory infections, such as a cold, to your supervisor and avoid handling food when you have them? Remember, any infections you have can be carried to others by the food you handle."

The employe undergoes training in proper attitudes to prepare him to serve the patient. He practices entering a room and greeting the patient, and learns how to meet the contingencies that arise in serving the patient.

Under the topic of sanitation the employe learns how to operate the dish machines. Correct stacking of dishes is stressed, as are: washing the trays; destaining dishes; keeping drains, cabinets and drawers clean.

Rigid sanitation is enforced in frequent inspection of fingernails — inspection not only from dietary staff but from top administration. The employe is cautioned to wash his hands after smoking, going to restroom, mopping, handling dirty dishes, using telephone in nursing station or in hallway, combing hair, changing clothes, blowing nose, or sneezing. Each individual is held responsible for carrying out these rigid sanitation regulations.

The new employe is put through an explicit routine of duties to be done when first entering the ward kitchen. Some of these duties are illustrated by charts in the employe handbook.

The handbook also covers the employe's full responsibility for tray covers, "cup towels," silver and food carts, including cleaning and return of food carts to main kitchen at specific times.

The employe is taught to be alert about special diet trays so that they have the correct foods. In connection with tray service, the manual says: "Do not touch the blades of knives, bowls of spoons, or prongs of forks when handling silver. Handle glasses near the bottom, not the rim, and cups by their handles."

A complete demonstration on "How To Wash Dishes" includes placing of all dishes, those to be put into plate racks with partitions and those to be put into flat open tray. Cups, cereal bowls, and food covers are not to be stacked two or more deep.

The dish machine must be drained and fresh water added to wash silver and glasses. To prevent germ contamination of clean dishes the worker must not handle dirty dishes and then clean dishes without washing hands.

The employe is warned: "No excuses will be accepted after you have been shown *how* to wash dishes."

Under the heading of safety, the manual states:

"Accidents are expensive to the employer and employe. To the employer, accidents cost time and money; to *you*, the employe, accidents cost pain, discomfort and sometimes money. In food service sections, mechanical failure of equipment and human carelessness are responsible for the majority of accidents. The commonest injuries resulting from accidents in the dietetic section are: injuries from mechanical equipment,

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strains, cuts, burns, electrical shock, injuries from falls, and poisoning. Accidents can be prevented by reporting mechanical defects in equipment to your supervisor immediately and by practicing safe work habits."

Under fire prevention, the employe is told that in food service operations there are many fire hazards, of which the careless employe is by far the most dangerous. A careful employe protects himself, his job, and his work area from fire. He recognizes fire hazards, he knows what to do in case of fire, and he employs proper methods in using and caring for work equipment.

To obviate injuries from mechanical equipment he is told to ask his supervisor for instructions when he does not know how to operate or clean a piece of equipment. He must: report mechanical defects promptly, even though it slows his work; avoid talking to or otherwise distracting fellow employes while they are working with power equipment; stand by a machine while it is operating, even though he could save time by leaving it to do other work, and use all available mechanical safeguards.

To avoid cuts he is taught to cut with the knife blade turned away, to let a knife fall when he drops it, and to keep knives sharp and the handles in good condition. He must cut on a board rather than "palming" fruit and vegetables and use a box cutter to open cartons.

To guard against electric shock he is told to dry his hands before handling any electric equipment, to remove a plug from a socket by grasping the plug not the wire, and to report all defective wiring immediately.

Injuries from falls are reduced by the following rules: Wipe up all spilled food immediately; mop floors in sections so that traffic can pass safely; approach corners carefully, especially when pushing trucks; put trucks, mop buckets, dollies or any other equipment against the wall if these must be left in corridors or traffic lanes; observe traffic rules in corridors, work areas, and doorways; dry hands before attempting to lift or carry equipment; use handrails on stairs.

Fully detailed daily (after each meal) cleaning duties for all employes are given. These cover serving areas and equipment, stove and dish machine. A weekly cleaning schedule, covering each day of the week, is divided into morning and afternoon cleaning duties.

For example, on Monday afternoon: "Clean the refrigerator thoroughly, inside and out and on top. When cleaning inside the refrigerator be sure to clean the drain plug." On Wednesday afternoon: "Straighten supplies. Make list of dish or silverware supplies needed and give to dietitian early. Destain all stained dishes."

Nothing is left to chance on floor mopping. For example, "Pour soapy water down floor drain to wash it out. Then pour clear water down drain. Wash out mop and mop bucket. Squeeze mop dry."

To drive home the importance of sanitation, especially in the hospital, the handbook concludes with a summation on sanitation.

The employe is told: "It is part of *your* job as a food service employe to handle food in a sanitary and careful manner to protect the individuals for whom it is prepared." Then follows a checklist of specific and general points that cover the whole food service area at which the principles of good sanitation must be maintained at all times. ■

FOOD FOR THOUGHT

How To Judge Potatoes

Bargains in potatoes are not always "true bargains" from the standpoint of preparation, according to Catherine Turner, assistant professor of home economics at the University of Alabama.

The price quoted per bag may be lower, she explains, but the product when ready to cook may be more expensive than a higher priced potato. Shallow-eyed potatoes are the most economical, as deep-eyed ones require more labor to remove the eyes and when peeled by machine result in greater waste, Miss Turner says. A smooth shallow-eyed potato gives the greatest yield per pound when prepared.

She passes along some suggestions from the United Fresh Fruit and Vegetable Association for speeding the baking of potatoes.

1. Bring water to a boil. Stir in table salt (about 2½ cups salt per gallon). Add potatoes of uniform size. They should float.
2. Boil for 20 minutes or until fork tender.
3. Place under the broiler for 5 minutes or into a hot oven to dry out and brown. ■

Menus for July 1959

Mary Harman Riste
Executive Dietitian
Butterworth Hospital
Grand Rapids, Mich.

1
Sliced Orange
French Toast, Sirup

•

Chicken Soup
Sauteed Veal Loin Chop
Baked Potato
Cut Wax and Green Beans
Fruit Cup Gourmet
Toasted Angel Cake

•

Vegetable Soup
Larded Beef Tenderloin
French Fried Potatoes
Romaine With Vinaigrette
Cherry Pie

2
Orange Juice
Soft Cooked Egg

•

Golden Nectar
Chicken Pie, Biscuits
Mashed Potatoes
Mixed Vegetables
Celery, Spiced Apricot
Pistachio Ice Cream

•

Beef and Rice Soup
Asparagus Tips on
Toast Points With
Hard Cooked Egg Sauce
Crisp Bacon Strips
Fruit Salad
Devils Food Cake

3
Half Grapefruit
Scrambled Eggs

•

Lime Juice Cocktail
Seafood Croquette
Escalloped Potatoes
Fresh Spinach
Strawberry Boston
Cream Pie

•

Creamed Tomato Soup
Cheese Souffle
Fresh Asparagus
Fruit Salad Bowl
Toasted Almond Ice Cream

4
Melon
Steamed Egg

•

Cream of Celery Soup
Rib Roast Beef au Jus
Noodles in Beef Juice
Perfection Salad Mold
Peach Cobbler

•

Fruit Cup With Candied
Mints in Grapes
Larded Veal Loin With
Fine Herb Sauce
Persillade Potatoes
Shredded New Beets
Cheese Cake

5
Half Grapefruit
Soft Cooked Egg

•

Eggdrop Soup
Baked Canadian Bacon
Escalloped Corn
Broccoli
Relish Plate
Pumpkin Pie

•

Consomme
Chicken and Rice Timbale
Asparagus Tips
Pear Salad Naturelle
Neapolitan Parfait
Coconut Snowball Cakes

6
Pancakes, Sirup
Sausages

•

Noodle Soup
Roast Leg of Lamb
Parslied New Potatoes
Green Peas Wanda
Cheese Stuffed Prunes
Grapefruit Sherbet

•

Vegetable Soup
Grilled Hamburger Steak
Clubbed Potato
Pickle Medley
Bibb Lettuce With
Roquefort Dressing
Cherry Roll

7
Tomato Juice
Poached Egg on Toast

•

Cranberry Juice Cocktail
Fried Spring Chicken
Tubed Potatoes, Gravy
French Green Beans
Sliced Water Chestnuts
Floating Island

•

Schnitzelbank Pea Soup
Turkey Sandwich
Buttered Broccoli
Fruit Salad Bowl
Chocolate Sundae

8
Grapefruit Juice
Scrambled Eggs

•

Melon Ball Cocktail
Rib Roast of Beef
Mashed Potatoes
Fresh Asparagus With
Hollandaise Sauce
Chocolate Ice Cream

•

Noodle Soup
Creamed Chipped Beef
in Parsley Crustades
Sauteed Mushrooms,
Green Frozen Peas
Fruit Salad Bowl
Chocolate Eclair

9
Prunes With Orange
Soft Cooked Egg

•

Consomme Royal
Roast Leg of Lamb
Rice Pilaf
Parslied Carrots
Tossed Greens
Jellied Mandarin Oranges
Ginger Cookies

•

Puree Mongole
Knickerbocker Supreme
of Chicken With Sauce
Broccoli
Chopped Potato Salad
Compote of Fruit

10
Sliced Orange
French Toast

•

Cream of Tomato Soup
Scrambled Eggs on
Parmesan Toast Points
French Fried Potatoes
Fresh Asparagus
Grapefruit and
Avocado Salad
Coconut Cream Pie

•

Lime Juice Cocktail
Broiled Whitefish
Waffled Potatoes
Buttered Tiny Beets
Burnt Sugar Cake

11
Orange Juice
Poached Egg on Toast

•

Tomato Juice
Roast Leg of Veal en
Herb Dressing
Pan Browned Potatoes
Fresh Spinach
Danish Custard

•

Asparagus Soup
Broiled Tenderloin Steak
Sauteed Mushrooms
French Fried Potatoes
Caesar Salad
Baked Fresh Rhubarb

12
Half Grapefruit
Soft Cooked Egg

•

Beef and Barley Soup
English Mixed Grill
Creamed Potato Balls
Broccoli
Celery Hearts, Olives
Pineapple Icebox Dessert

•

Burtsch
Pennsylvania Meat Loaf
Stuffed Potatoes
Artichoke Salad Aveline
Lemon Meringue Pie

13
Orange Juice
Pancakes, Maple Sirup

•

Consomme Julienne
Roast Turkey Breast en
Rice and Mushrooms
Giblet Gravy
Fresh Asparagus Tips
Pear and Cheese Salad
Pistachio Ice Cream en
Sponge Cake

•

Nectar With Fruit
Baked Veal Chop
Mixed Vegetables
Marble Layer Cake

14
Honeydew Melon
Broiled Sausages

•

Cream of Corn Soup
Rouladen in Brown
Sauce
Mashed Potatoes
Buttered Celery and
Mushrooms
Small Relish Plate
Blanc Mange Mold

•

Vegetable Soup
Toasted Bacon and
Tomato Sandwich
Pickle Chips
Jellied Fruit Salad
Caramel Ice Cream

15
Fresh Strawberries
Coffee Cake

•

Cranberry and Orange Juice
Fried Chicken
Glazed Sweet Potatoes
Buttered Green Beans
Vanilla Ice Cream

•

Cream of Tomato Soup
Yum Yum Sandwich
Potato Chips
Mixed Pickle Garnish
Fresh Fruit Cup
Sugar Cookie

16
Orange Juice
Soft Cooked Egg

•

Tomato Bouillon
Pot Roast of Beef
Mashed Potatoes With
Brown Herb Gravy
French Fried Asparagus
Celery Hearts and
Carrot Shreds
Glazed Peach Tarts

•

Fresh Pineapple Cubes
Fried Smoked Ham
Escalloped Potatoes
Broiled Tomato
Spice Cake

17
Half Grapefruit
Coffee Cake

•

Golden Fruit Cup
Fried Mock Scallops
Parslied New Potatoes
Sliced Carrots
Chocolate Chiffon Pie

•

Consomme Royal
Baked Trout
Spanish Rice
Small Relish Plate
Sliced Peaches
Sugar Cookies

18
Prunes With Orange
Poached Egg on Toast

•

Cream Princess Soup
Beef Stroganoff on Rice
Broccoli
Bibb Lettuce Rose With
Aveline Dressing
Fruit Lorette
Cornflake Cookies

•

Roast Leg of Lamb
Mashed Potatoes, Gravy
Peas and Carrots
Jellied Fruit Salad
Chocolate Angel Cake

19
Fresh Grapefruit
French Toast, Sirup

•

Oxtail Soup
Corned Beef Brisket
Potatoes O'Brien
Spinach Souffle
Small Relish Plate
Pumpkin Pie

•

Tomato Juice
Veal Casserole
French Green Beans
Bibb Lettuce With
Orange Slices
Custard Ice Cream

20
Melon
Soft Cooked Egg

•

Chicken Fricassee
Mashed Potatoes With
Parsley Gravy
Macedoine of Vegetables
Pepper Slaw
Peach Cobbler

•

Vegetable Soup
Hamburger Sandwich in
Buttered Rusk Bun
Potato Salad in Romaine
Fresh Fruit Cup
Icebox Cookies

21
Fresh Strawberries
Scrambled Eggs

•

Beef and Mushroom Loaf
Diced Potatoes au Gratin
Whole Green Beans
Jellied Fruit Salad
Orange Layer Cake

•

Cream of Carrot Soup
Shepherd's Pie With
Tubed Potatoes
Asparagus Tips
Coupe Louisiana
Chocolate Frosted Cookie

22
Orangeade
Broiled Bacon

•

Consomme Julienne
Roast Tom Turkey
Stuffed Potatoes
Carrots and Peas
Stuffed Celery Hearts
Tutti-Frutti Parfait

•

Cream of Corn Soup
Chicken and Ham Sandwich
Potato Chips
Jellied Fruit Salad
Fudge Loaf Cake

23
Blended Juice
Poached Egg on Toast

•

Mushroom Soup
Sliced Sirloin Steak
Alphonso Potatoes
Pickle Relish, Olive
Cherry Pie

•

Chinese Soup
Macaroni and Cheese
Broccoli
Bibb Lettuce With
Celery Seed Dressing
Strawberry Shortcake

24
Half Grapefruit
Soft Cooked Egg

•

Meatless Vegetable Soup
Broiled Whitefish
Stuffed Potatoes
Paprika Cauliflower
Fresh Fruit Salad
Black Bottom Pie

•

Creamed Spinach Soup
Toasted Cheese on Cracker
Egg Souffle en Mushrooms
Chef's Salad Bowl
Peach Sundae

25
Honeydew Melon
Soft Cooked Egg

•

Roast Veal, Dressing
New Potatoes O'Brien
Buttered Green Beans
Sliced Tomato and Lettuce
Chocolate Pie

•

Clam Chowder
Chicken Chow Mein en
Toasted Noodles
Broccoli Tips
Plate of Sweets

26
Half Grapefruit
Scrambled Eggs

•

Tomato Juice
Swiss Steak
Mashed Potatoes
Frozen Peas
Prune Whip

•

Cream of Celery Soup
Poached Egg on Canadian
Bacon and Buttered Rusk
Broccoli
Fruit Salad Bowl
Date Torte With
Ice Cream Topping

27
Orange Juice
French Toast, Sirup

•

Noodle Soup
Baked Ham
Glazed Sweet Potatoes
Fresh Spinach
Pink Lemonade Sherbet
Lady Baltimore Cake

•

Cream of Asparagus Soup
Broiled Ground Steak
Mushrooms Julienne
Fordhook Limas
Tossed Salad
Fresh Pineapple, Banana

28
Honeydew Melon
Soft Cooked Egg

•

Sauteed Spring Chicken
Mashed Potatoes
Buttered Green Beans
Celery Hearts
Baked Rhubarb
Sand Tart Cookie

•

Cream of Pea Soup
Creamed Chipped Beef
on Buttered Rusk
Asparagus Tips
Butterfly Salad
Key Lime Pie

29
Pineapple Juice
Broiled Bacon

•

Mushroom Soup
Roast Beef
Parslied Potato
Diced Harvard Beets
Bunch of Greens Salad
Orange Bread Pudding

•

Grilled Lamb Chop
Escalloped Potatoes
Green Salad
Fresh Fruit Cup
Toasted Angel Cake

30
Orange Juice
Sausage

•

Lime Juice Cocktail
Chicken Pie With Biscuit
Mashed Potatoes, Gravy
Cauliflower and Peas
Strawberry Ice Cream

•

Beef and Parsley Soup
Macaroni and Cheese
Asparagus
Fresh Fruit Salad
Sunshine Cake

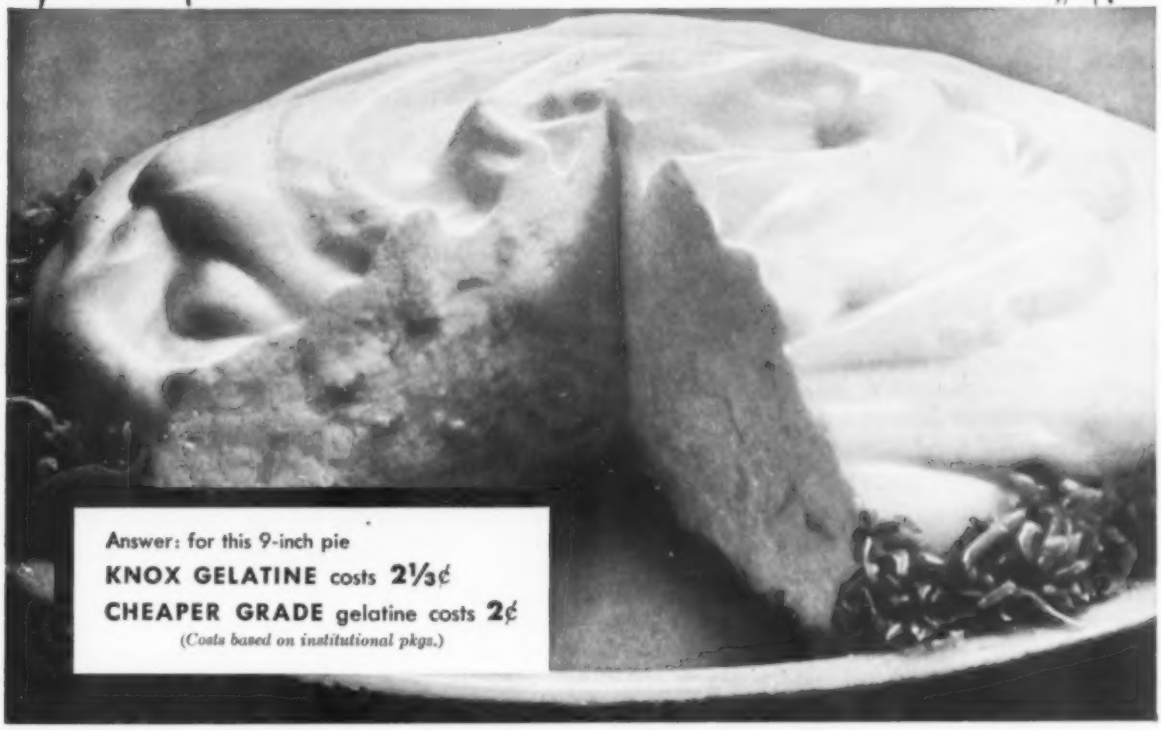
31
Tomato Juice, Scrambled Eggs • Cream of Mushroom Soup, Frenched Haddock Fillet, Latticed Potatoes, Spinach, Green Citrus Cocktail, Maraschino Icebox Dessert • Rice and Celery Soup, Scrambled Eggs on Melba Toast Points, Asparagus Tips, Fresh Fruit Salad With Avocado, Butter Cake.

Ready-to-eat or cooked cereal served on all breakfast menus.

GUESS

what the unflavored gelatine costs for this Lemon Chiffon Pie...

(answer below)



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Specify KNOX GELATINE in the new economical 3-pound package. You get more servings per pound with KNOX.

KNOX GELATINE, INC.
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What Automation Does for Laundry Service

By redesigning its laundry from two small, inadequate plants into one large, well planned and fully automated structure, this hospital increased laundry production from 260,000 to 800,000 pounds of linen per month, with a shorter work week

Horace W. Cooper, Joseph F. Krawiec, and David E. Dodson

THE laundry plant at Philadelphia State Hospital is one of the largest single institutional laundries in the world. It has more than 75,000 square feet of floor space. The modern, automatically controlled equipment is designed to serve the needs of 8000 patients and personnel.

The plant is the result of several years' careful planning in cooperation with leading laundry equipment manufacturers, architects and engineers; laundry research personnel from Pennsylvania State University, and representatives from the state department of welfare and the hospital.

At the time this article was prepared, Mr. Cooper was business manager of Philadelphia State Hospital. He has since retired. Dr. Krawiec is laundry technologist, Pennsylvania State University, and Mr. Dodson is laundry supervisor of Philadelphia State Hospital.

All work previously had been processed in two small, inadequate laundry plants. During the fiscal year 1946-47 these laundries processed approximately 260,000 pounds of soiled linen each month for a resident census of 7700. Good work was impossible because of overloaded washwheels and a short washing formula. In 1950 each plant was forced to operate on two eight-hour daily shifts, Monday through Friday and until noon on Saturday, to meet the increased demand for clean bedding and apparel. This working schedule was maintained until December 1953, when the new plant was opened.

The new plant can process some 800,000 pounds of laundry per month in a 40 hour work week. Approximately 250 patient workers are assigned for laundry training under the supervision of 44 employes in the various laundry departments. The total cost of the new laundry was approximately $1,700,000, of which $1,000,000 was for the building and $700,000 for equipment.

The over-all dimensions of the U-shaped building are: length, 355 feet; width, 161 feet, and height, 46 feet. The ceiling height of the main floor is approximately 19.5 feet. The washing, extracting, flatwork, rough-dry, pressing departments, the mechanics shop, and air conveyor system are located on the main floor. The loading platform can accommodate three large trucks simultaneously and is recessed into the building to provide proper protection during inclement weather.

(*Continued on Page* 152)

Three shake-out tumblers. One is unloading clothes into pneumatic conveyor hopper for transportation to driers.

Flatwork ironer area contains nine standard machines. At left is flatwork conveyor belt with tumblers in back.

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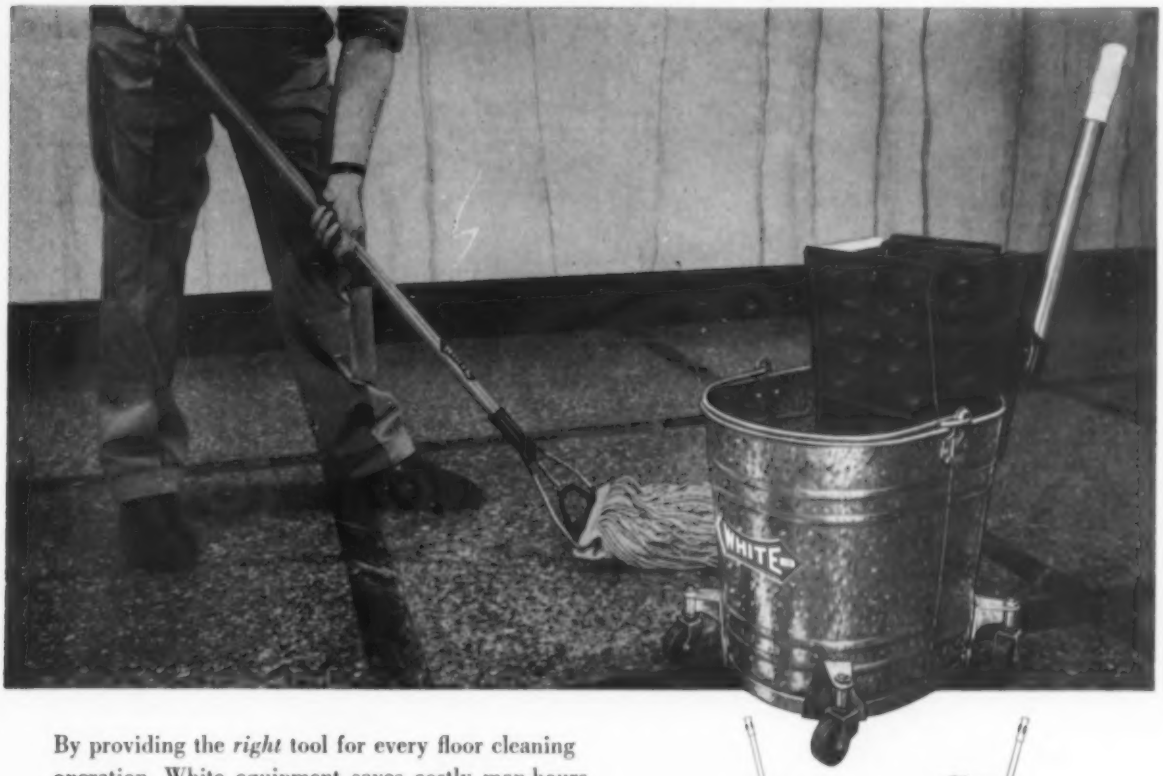

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PHOTO: Tymsaver Mopping Outfit combines powerful "Can't Splash" Wringer with White heavy duty oval bucket. Assures a cleaner, dryer mop after each squeeze, for economical, efficient cleaning.

***SKETCH A:* Downward Pressure Wringer; new splash pad makes wringer mechanically sound, trouble-free for years.**

***SKETCH B:* "Can't Splash" Wringer; 16-to-1 leverage squeezes large mops dry with little more effort than it takes to shift gears in a car!**

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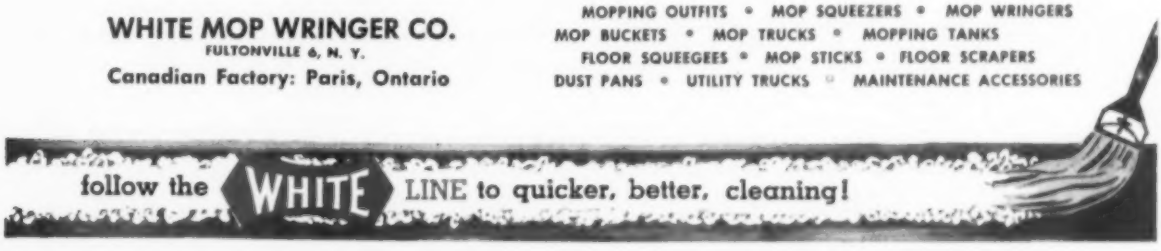

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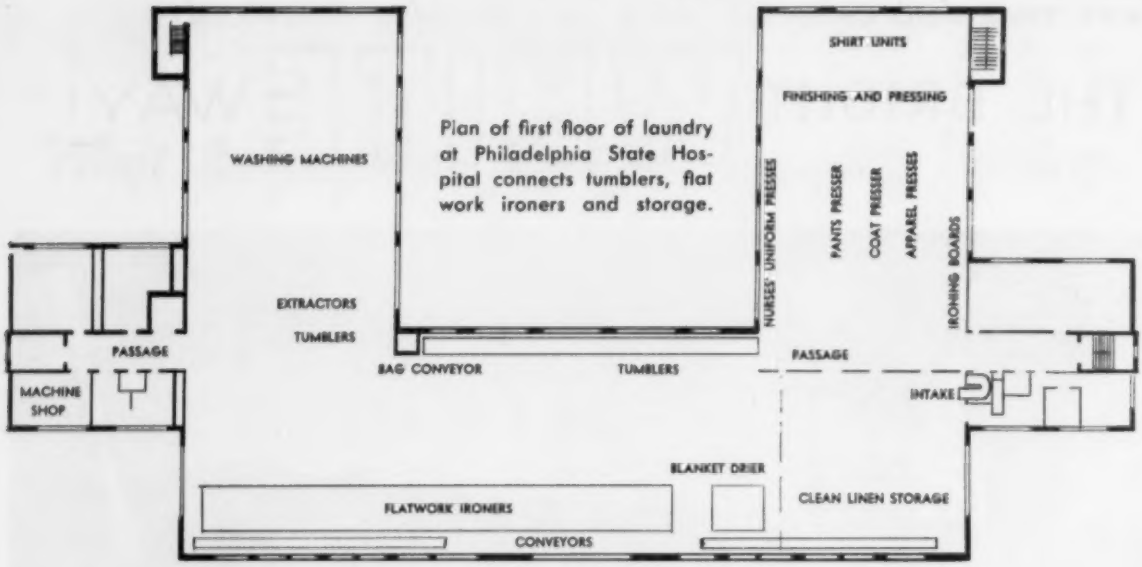

Plan of first floor of laundry at Philadelphia State Hospital connects tumblers, flat work ironers and storage.

(*Continued From Page* 150)

A vertical lift (bag conveyor) moves all soiled work from the ground floor to the sorting room. A belt conveyor transports all finished flatwork, such as sheets, pillowcases, bedspreads, and hand towels, to the central distribution room on the ground floor. An electrically controlled pneumatic conveyor system transports the damp clean linens by air suction at a speed of nearly 60 miles per hour through 14 inch metal ducts to the flatwork ironers, tumbler driers, and pressing departments. The rough-dry garments and fabrics from the drying tumblers are carried through a similar system to the central distribution room on the ground floor below for folding, identification and delivery. A large freight elevator provides service for general use between all floors.

The vertical lift or bag conveyor is located near the recessed loading platform. Bagged soiled linens are removed from the motor trucks and placed on the bag conveyor which delivers them to the soiled linen room at the top floor, at the rate of five bags per minute, for sorting and weighing. If the bag conveyor should fail to operate properly the soiled linen can be transported on the freight elevator. It has a capacity of 3000 pounds and is capable of lifting a full load 32 feet to the top floor in about 30 seconds.

The central supplies room, located just to the left of the loading platform, contains a divided stock soap tank. Each section of the soap tank has a capacity of approximately 2000 gallons. The prepared liquid soap stock mixture is pumped to the washwheels through a continuous pipe loop at the rate of 120 gallons per minute at a temperature of 150 to 155° F. There are also three rubber lined tanks, each with a capacity of 266 gallons, for chlorine bleach, sour and blue solutions. Each prepared mixture travels through lined pipes to each washwheel under 15 pounds air pressure.

The mechanical equipment room, adjacent to the central supplies room, contains a dual water softening plant; three hot water generators; a heat reclaiming unit; a preheater; two hydropneumatic tanks, and one open surge tank. The two water softening units, each with 112 cubic feet of styrene synthetic resin zeolite, have an exchange rate of 26,000 grains of hardness per cubic foot. The flow rate of each softening unit is 350 gallons per minute. The two hydropneumatic tanks store 5000 gallons of softened water under 100 pounds air pressure so that a constant pressure can be maintained at the washwheels (through an automatic valve control) should the city water pressure drop below normal working pressure. The water supply in these two hydropneumatic tanks is replenished from an open surge tank by centrifugal pumps.

All the softened water heated in the three hot water generators passes through a heat reclaimer (4 feet wide, 18 feet long, and 7 feet deep) with a series of coils through which the water travels. These coils have a total surface area of more than 3000 square feet, and are capable of raising the temperature of 22,000 gallons of water per hour from 40° F. to 90° F. The heat is reclaimed from the waste water dumped from the washwheels during the washing cycle. After the water leaves the heat reclaimer it continues to a preheater (14 feet long and 5 feet in diameter) where the temperature is further raised by utilizing the steam condensate from the equipment and heating units. This water then passes to a series of three hot water generators, each with a capacity of 3200 gallons, connected in parallel and heated with high pressure steam at boiler pressure.

The air compressor room has three single-stage, horizontal, water-cooled, double-acting compressors with 9 by 9 inch cylinder bore and stroke. Each air compressor is operated by a 20 h.p. motor and is capable of furnishing 135 cubic feet of air per minute at 100 pounds pressure. As the air leaves the compressor it passes through a water cooled after-cooler to remove moisture and lower the temperature.

The clean linen distribution center is located to the right of the recessed truck loading platform. This center receives all the finished linens from the flatwork ironers on a belt conveyor from the main floor above. The rough-


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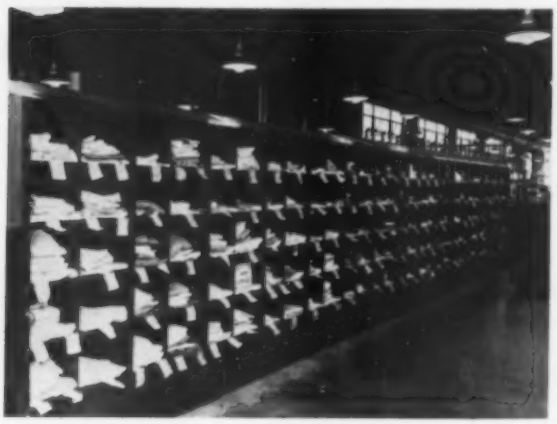
View of the washroom showing eight of the 20 fully automatic washwheels, with one unloading into special truck.

Northeast wing contains the press room with 77 presses and 15 hand ironing boards for personal finishing.



Left: Sorting area with some of the 1160 steel classification cubicles used to segregate personnel laundry by lists.

dry garments and items from the drying tumblers arrive at the clean linen center through the air conveyor system and the finished work for personnel comes down a spiral chute. At the clean distribution linen center the linens and garments are sorted, assembled and checked out to the various buildings of the hospital.

All institutional items that require mending are removed from service at their respective finishing areas and sent to the laundry mending room. The laundry mending room restores thousands of items to serviceable condition each month.

The linen storage room, located between the clean linen distribution center and the mending room, is equipped with steel shelves adequately stocked with new linen and garments. Any damaged items that cannot be mended are replaced from stock. This system permits the laundry department to keep an adequate supply of linen and garments in circulation.

The most vulnerable operation in any hospital laundry plant is maintenance, including efficient preventive maintenance. At Philadelphia State Hospital, a maintenance department was included within the laundry plant. The shop is equipped with the necessary tools, spare parts and equipment to make all primary repairs, adjustments and lubrication of all laundry machinery.

The washroom, extractor and shakeout departments are located in one wing. There are 20 fully automatic washwheels with pneumatic controls; 18 are 42 by 96 inches in size, each with a normal dry weight capacity of 320 pounds, two of which have dual speed motors that adapt the machines for slow speed laundering (10 to 12 r.p.m.) of woolens. The remaining two washwheels are 42 by 54 inches in size, each with a normal dry weight capacity of 180 pounds. The washroom also has one small semiautomatic washwheel (36 by 54 inches in size) with a normal dry weight capacity of 130 pounds.

Every washing operation is carried out automatically by means of perforations on a special paper tape similar to a player piano roll. These perforations on the tape activate the various valves of the automatic control to measure and inject the supplies, select the proper water levels, attain proper washing temperatures, control the washing time of each cycle, close and open the dump valve, and signal and stop the machine at the end of the washing formula. Twenty of the 21 washwheels are loaded directly by gravity chutes which project downward from the soiled linen sorting room. The overhead soiled linen sorting room permits loading of the 20 washwheels by gravity and isolation of all the soiled linen, thereby preventing contamination of the laundered and processed linens and garments. The 20 fully automatic washwheels are of the unloading type which eliminate the backbreaking task of pulling laundered linens out of the washwheels.

The processed load in each washwheel is emptied into specially designed trucks of 160 pound capacity and are slid into the two hydraulic extractors for a seven minute extracting cycle. The excess water from the laundered fabrics is squeezed out rather than centrifuged. There are

(*Continued on Page* 158)

new hospitals specify 7

TOP: LEFT TO RIGHT

Hughes Spalding Pavilion Hospital
Architect: Abreu and Robeson

Grady Memorial Hospital For The Fulton-Dekalb Hospital Authority
Architect: Robert and Company Associates

Georgia Baptist Hospital
Architect: Stevens and Wilkinson

Henrietta Egleston Hospital For Children
Architect: Abreu and Robeson

BOTTOM: LEFT TO RIGHT

St. Joseph's Infirmary
Architect: Abreu and Robeson

Piedmont Hospital
Architect: Shutze, Armistead, Saggus and Associates: Williamson, Vaught, and Spiker

Kennestone Hospital
Architect: Abreu and Robeson

Patient's room lavatory has wide ledge, back splash, wrist-control handles . . . with or without return end. Genuine vitreous china in eight colors and white.

Wall-hung toilet has self-closing, pedal-operated bedpan washer. Lugs are cast into rim of bowl to hold pan in washing position.

American-Standard fixtures throughout

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Durability, convenience, sanitation. Functional design of American-Standard fixtures and fittings results from providing sanitary products to the nation's hospitals for many years. Non-porous vitreous china, enameled cast iron fixtures and chrome-plated fittings meet highest hospital standards of durability, convenience and sanitation.

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three standard 48 inch open-top extractors which are used primarily for centrifuging woolen garments, wearing apparel, and starched items not adapted to hydraulic extraction. A small 26 inch diameter solid curb extractor adjacent to the small washwheel completes the extracting department. This small washwheel and extractor handles the reruns and small lots.

Three large 72 inch diameter shake-out tumblers break up and shake out the tightly compressed cubes of linens from the hydraulic extractors. After each cube of linens has been separated and properly shaken out, it is dumped onto tables from which it enters one of the four pneumatic conveyor systems for distribution to the various departments of the laundry plant.

Each pneumatic conveyor system is powered by a 60 h.p. motor located in the fan room near the laundry office. The air is drawn through 16 inch air ducts at the rate of approximately 60 miles per hour and the damp linens travel through 14 inch ducts at the same speed to the receiving stations. Three of these four systems that handle the damp linens from the tumblers serve the flatwork ironers at the rate of 4300 pounds per hour. Sixteen specially designed canvas lined shake-out trucks (84 by 48 by 23 inches) with flared sides receive the loads that are dumped from the overhead collectors.

The fourth air conveyor system transports the damp garments and other items to the drying tumblers and the finishing department at the rate of 2300 pounds per hour. A fifth pneumatic conveyor system moves the dried rough-dry work from the drying tumblers to the ground floor distribution center at the rate of 3200 pounds per hour. The conveyor system reduces the need for many trucks, provides unobstructed working areas, and eliminates many man-hours of carting work to the various departments.

The flatwork department has seven six-roll, 110 inch width, standard ironers and 2 eight-roll 110 inch ironers with automatic folders. A continuous conveyor belt (225 feet by 24 inches wide) at the rear of the nine flatwork ironers carries all the folded flatwork to the distribution room on the ground floor. Along the wall opposite the flatwork ironers are five 42 by 120 inch three-pocket drying tumblers and three small 36 by 30 inch open end tumblers.

Two centralized lint collectors have eliminated lint screen on the individual driers. The lint-laden exhaust from the driers passes through a water spray which washes the lint into a net for easy disposal. This prevents the fire hazards of dry lint.

The five large drying tumblers each have a dry weight capacity of 160 pounds and the small driers a capacity of 32 pounds each. The drying tumblers are loaded automatically from an overhead storage hopper served by the conveyor system. The rough-dry work is dropped from the tumblers into the conveyor system receivers, mounted in front of each compartment, and carried to the distribution center for folding, sorting, segregation and shipment.

The finishing and pressing department is located in the other wing of the U-shaped building. This large room has spacious windows on three sides providing excellent natural light and ventilation. The pressing equipment in this department comprises 33 units of 77 individual presses. In addition each complete pressing unit has a stainless steel damp box and a spray gun. The finishing equipment

Seventh in a series

DAGE CLOSED-CIRCUIT TELEVISION

The Dage camera in the F-102B chase plane provided "eyes" for thousands of spectators viewing the Air Force's World-Wide Weapons Meet.

The 10 lb. Dage camera, connected by closed-circuit to the home TV set, serves as a swimming pool monitor. It is available through Abercrombie & Fitch, New York, at $1495, including installation and one year's service.

To track a jet

or watch a child...

Another TRW product proving its value in military and commercial use

Not long ago a small closed-circuit television camera—weighing only 4 pounds and no bigger than a home movie camera—made television history. The Dage TV camera, carried in chase planes and located at strategic points on the vast gunnery range of the Air Force's Fighter Interceptor World-Wide Weapons Meet, recorded the supersonic flights of F-102s from scramble to kill. What it saw was transmitted back to TV screens in monitor stations.

In dramatic firsts like this, the Dage Television Division of Thompson Ramo Wooldridge Inc. is leading the closed-circuit TV field in number of installations and in technical achievements. Dage TV systems are being used to provide faster and more complete weather briefings for remote air bases, help control turnpike traffic, instruct salesmen, and aid in hospital education, surgical observation and consultation. Around the home, the Dage TV camera can be used in monitoring the swimming pool, watching the baby or the front door. Dage Television Division and its products are typical of the way Thompson Ramo Wooldridge serves its customers in meeting the demands of today's technology.

TRW

Thompson Ramo Wooldridge Inc.

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also includes 15 electric hand irons and ironing boards.

The sorting area for finished laundry for personnel is adjacent to the flatwork ironer and finishing-pressing departments. This department has 1160 steel classification cubicles to segregate finished laundry as checked from individual laundry lists. The finished laundry is then packaged and slid down a spiral chute to the distribution room for shipment. All uniforms are placed on hangers on a movable garment rack and transported to the nurses' and attendants' quarters.

The soiled linen room is in one wing above the washing department. All soiled laundry received at the ground floor level is transported by the bag conveyor to this area for checking, classification and weighed on the two floor-level platform scales in 160 pound lots. It is then placed in the 40 gravity chutes that drop the soiled work into the 20 washwheels. The working area has a waterproof quarry tile floor, ceramic tile wainscoting, and several hose bibs and floor drains to facilitate frequent cleaning. Adjacent is another room where employes' laundry is sorted, marked and classified.

The laundry manager's office has an extensive intercommunication system which serves to coordinate all plant operations. It is located on a mezzanine floor and furnishes an unobstructed view of the main floor area, with the exception of the washroom section. Auxiliary intercommunication lines connect with the bag conveyor operator on the ground floor, the washing department on the main floor, and the soiled laundry receiving room on the top floor.

Key personnel consists of a chief laundry manager, who is responsible for all operations in the plant, and four supervisors responsible to the manager. Personnel such as maintenance mechanics, office clerk, and janitor operate directly under supervision of the chief laundry manager.

Comfortable working conditions are maintained by 15 large exhaust fans which remove the hot humid air and five large ventilators which replenish the areas with clean fresh air. Large blue-tinted glass windows and approximately 600 light fixtures provide ample light for all operations. Seven electrically cooled drinking fountains; six locker rooms with 300 lockers; four restrooms and 11 toilet-washroom facilities are provided.

Since the opening of the new facilities the institution has been able to furnish the patient with more clean linens and pressed clothing. During 1953 the two former laundry plants, each working on two 44 hour weekly shifts, were producing approximately 59.9 pounds of flat finished work and rough-dry articles per patient per month. With the opening of the new laundry, operating on one 40 hour shift in 1954, the pounds of clean linens and clothing per patient per month was increased to approximately 68.6 pounds. This represented an increase of some 9 pounds per patient per month. With many of the initial "bugs" of any new plant adjusted and eliminated the monthly poundage has increased steadily. It is anticipated that the poundage per patient per month will reach the 100 pound goal.

A careful examination of laundry records reflecting the quantity of laundry supplies consumed during 1953 in the two former laundry plants *versus* the new laundry facilities during 1954 was illuminating.

On a dollar value basis the new plant reduced the cost of alkali, soap compounds, soap flakes, and starch by

1. BACTERIOLOGY of the BEDSIDE CARAFE, Walter, C. A., Rubenstein, A. D., Kundsin, R. B., Shilkret, M. A.: New England J. Med. 259: 1198-1202, Dec. 8, 1958

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$8,303.67. The new laundry facilities consumed more bleach ($46.64), more sour ($276.90), and purchased salt for the water softening units ($771.84) for a total of $1,086.38. Even with these additional charges the net reduction in cost was $7,217.29. During this same period the new plant has also processed additional soiled work totaling 517,463 pounds.

The saving in washing supplies is attributable to a number of factors, some of which may appear unimportant to the laundry manager. Factors responsible for the excessive usage and waste of laundry supplies are:

1. The soiled work processed in the former plants was laundered in water with an average hardness of 3.4 grains per gallon. Water hardness as low as 2 grains per gallon has a direct relationship to increased consumption of supplies. Soiled work is processed in the new plant with water of zero grains hardness per gallon.

2. The hot water supply in the former facilities was inadequate, seldom averaging more than 100° F. Heating of water in the washwheels to 160° F. (white classification formula) with live steam is a haphazard and inefficient laundry practice. Proper washing temperatures seldom are attained under such conditions, especially in the large 54 by 120 inch washwheels. Waste of alkali, soap and other supplies along with an inferior grade of work is the final result. The new laundry has an adequate constant supply of 180° F. hot water.

3. The washwheels in the former laundries were overloaded beyond normal capacities, and as a result, excessive quantities of alkali and soap were added in an attempt to produce fair quality work. In the new plant, washwheels are loaded to normal capacities – approximately four pounds of dry weight per cubic foot of space in the washwheel cylinder. Under these conditions it is possible to control the supplies and obtain the best work. Any washwheel that is supplied with lukewarm water, rather than hot water (160° F.), with 3.4 grains hardness per gallon and is overloaded becomes sluggish, inefficient and a wasteful consumer of washing supplies. The figures strongly indicate that softened water (zero grains per gallon) along with the processing of normal loads with an adequate supply of hot water (180° F.) are essential to produce best quality work and keep washing cost at the minimum. ■

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We Save So Much When We Standardize

A housekeeper and a purchasing agent of a large county hospital tell how standardized specifications result in cost savings and reduce the number of articles to be handled

Mildred F. O'Donnell

ABOUT a year ago a standardization committee was organized by Alameda County Hospitals, Oakland, Calif., to set up specifications on bedding, clothing, mattress cores (foam rubber mattresses), rainwear, textiles, pillows and shade material.

Those serving on the committee were appointed by the administration. Represented were the director of housekeeping services of the three medical institutions, assistant director of Juvenile Hall, superintendent of the county building, a technical adviser from public works, a supply officer from the county jail, and the assistant purchasing agent for the county. Only three people on the committee were using products being standardized. The other three acted as a "balance" in case someone's preferences got out of hand.

The first consideration of the committee was to spell out specifications so that the purchasing department would have standards and could provide vendors with reasonable specifications to bid on.

Once the specifications are established and accepted, *no one* can change them unless a soundly reasoned request for a change is submitted in writing to the committee.

The format for developing standards and specifications will be explained by Eugene Nichols in his article written from the purchaser's point of view (*p.* 166). He, as a purchasing agent, and I, as a housekeeper, feel that we have benefited so much from the committee's work that we would like to share the results.

The principle used in setting up standards was to minimize the number of items to *conform to the best usage* for the *greatest number*. For instance, the three medical institutions had used dressing towels with borders in five different colors and striped towels in two different colors. Although name woven sheets, pillowcases and towels were used, some of the institutions used two colors, one for the hospital, another for the residential quarters. Here, then, was an area for simplification. Two dressing towels, only, were standardized – a border towel and a stripe. Colors in name woven materials were used to denote institutions, that is, blue for one, green for another, and so on. Employes' linens were simply marked "EMP" with a marking pen.

Another standard was determined for definite colors for adults' and children's pajamas. Extra tops were purchased for adults as tops wear out more quickly. The children's pajamas are bought in color according to size: pink, 2 to 4; blue, 4 to 8, and green, 8 to 12.

Standardization, therefore, has served two purposes for housekeeping; it has cut down the number of articles to be handled and has simplified matching articles, such as adult and children's pajamas, by color. It is good to know that we shall always be able to match pajamas and can pick up the children's pajamas to size by color.

Salesmen no longer put pressure on the housekeeper to buy products. Through education they know that our specification do not change.

Specifications have given us good quality merchandise at a good price. How good, Mr. Nichols points out in his article.

The outgrowth of this committee has been proper ordering procedures. The purchasing department is given a list of requirements for our institutions by July 1 and knows through prearrangement that all three medical institutions will order supplies simultaneously every three months. This assures the housekeeping department of prompt deliveries. Purchasing, on the other hand, must realize savings, which, at the same time, keep down housekeeping costs.

Another tremendous advantage of established specifications has been the simplification in writing requisitions. No longer is time spent writing long detailed specifications. One merely orders "as per specs."

In addition to these advantages, I have gained much knowledge through association with other county sections.

(*Continued on Page* 166)

Mildred O'Donnell is director of housekeeping services, Alameda County Medical Institutions, Oakland, Calif.

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During sessions of discussion we have "aired" some of our difficulties and received real help from other members of the committee. The association has been a truly good morale builder for one feels he or she is part of something worth while, that one belongs, and that an honest, unbiased look at standards and specifications definitely pays off in dollars and *sense*. ■

Simplification and Standardization Both Help To Reduce Number, Cost of Purchase Orders

Eugene Nichols

OF THE many purchasing tools available to the purchasing agent, standardization is perhaps the most useful. Also closely allied to standardization is simplification.

To give an example of simplification, this happened in our county: Through a study of the county requirements by the standards subcommittee on clothing and textiles, we were amazed to find a repetition of several items under different names. For instance, "coats, doctors' "; "coats, laboratory technician"; "smocks, laboratory." When you multiply these by three major hospitals and the health department that use this garment, it becomes quite a substantial item. This led us to examine this particular item to determine what the special requirements were for each garment.

It developed that these garments were very similar in construction and also, apparently, in use. A meeting was held with the medical and technical staffs to discuss these variations and try to bring them into agreement on one garment. This agreement was reached with no difficulty. Thus, through simplification, we are now ordering one garment for all uses in this area.

To standardize on doctors' coats, the question was asked: What does the county require in the way of a doctor's coat? The weight of material was considered; the number of pockets and their location; the type of button, detachable or fast; belt, and the stitching in the seams. The following are our detailed standard specifications for doctors' coats: These coats are to be made of white sanforized cotton jean twill; the weight of the material is to be 2.85 pounds per yard; knee length coat style with four-button front, detachable pearl buttons, long sleeves, one breast pocket, and two hip patch pockets, with reinforced side slash opening; all seams are to be flat felled and sewed with two-needle stitch, number of stitches per inch to the seam is 10 to 12. The 10 to 12 stitches per inch were determined after certain tests using the Scott testing procedure. These are now the standard specifications for doctors' coats in the county of Alameda and cannot be changed without the permission of the standards committee.

In checking the saving on this item, I found that in the past year we made seven separate purchases of doctors' coats. The cost to this county to make a purchase is estimated at $10 per purchase order. This includes sending out bids, receiving at our central stores, and transhipping to the using department. Last year the seven purchases cost the county $70.

Under the new specifications, there will be one purchase order at $10, or a saving of $60 on this item alone.

In our subsequent discussions, the same situation developed in many areas, *i.e.* shoes, blue jean trousers, and chambray shirts, to name a few.

Savings from this combination of simplification and standardization are many. Now we can put out one bid and make one purchase for all the county's requirements for a year's use. Specifications are such that we are assured of ample competition at a competitive price.

The best specifications written would have no value if the material purchased were not tested and inspected to see if it meets our requirements. It therefore becomes the duty of the subcommittee on textiles and clothing to check out each shipment as it is delivered. This inspection has two main advantages: to catch possible errors by the shipping department, and to control the unscrupulous supplier who may try to palm off garments which do not meet our specifications.

Our goal is to incorporate requirements, set definite standards, and establish detailed specifications to be used as a basis for future purchases on all items used by this county. ■

Eugene Nichols is assistant purchasing agent, Alameda County Medical Institutions, Oakland, Calif.

Rules That Bend Aren't Often Broken

(*Continued From Page* 71)

Little that is constructive can be said upon the question of efficiency, as such, because it is to be taken for granted that every chief officer seeks to obtain the most efficient staff available. Efficiency is so frequently a technical matter (*e.g.* shorthand and typing speeds) that there is sometimes a tendency to divorce it entirely from personal qualities.

Such a view of efficiency is, in general, a mistake, certainly as regards senior and intermediate officers whose performance must be looked at as a whole and who cannot really be regarded as "efficient" if they are efficient only in a technical sense but are deficient in personal qualities of leadership and cooperation. Efficiency in the narrow technical sense may even be a menace, and it is not infrequently that one encounters the department head whose own standards of performance are so high and whose standards of toleration and understanding so low that none of his subordinates is able to give satisfaction.

When such a situation exists there is stress, disturbance and high staff turnover in that particular department. How can such a departmental chief be considered efficient if he cannot keep his department running smoothly and happily? It is, in practice, much better to aim at 90 per cent efficiency with a happy, secure and contented staff, than to strive always for 100 per cent efficiency at the cost of a disgruntled, stressful and antagonistic staff. In hospitals, "efficiency," as such, is to some extent suspect; "effectiveness" is a much better concept.

It is for the chief officer to create an atmosphere in which members of his staff can work most effectively. Although he may not choose to issue detailed instructions, he should nevertheless ensure that each member of his staff knows pretty accurately where his responsibilities begin and end, where he may act upon his initiative, and where he should refer upwards for a decision. As a general rule, responsibility should be delegated wherever possible so that decisions can be taken as close as possible to the circumstances and factors upon which decision can be made. It is a common error to assume that responsibility cannot be safely delegated. Most subordinate officers respond to responsibility and do not abuse or misuse it. ■

Although there may be some exceptions, an organization that provides for all decisions, small as well as large, to be made at the highest level is usually defective and inefficient. It carries the seeds of its own destruction in that, in time, all subordinate officers become incapable of making decisions while the chief officer wastes most of his time in deciding matters too small to warrant his attention and too remote for him to understand. As hospitals are forced by the circumstances of their work to provide for decisions to be taken at so many levels other than the highest, they do not, in general, suffer as do some other organizations from the type of overcentralization referred to.

The danger is not entirely absent in hospitals, however, and it is for the chief officer to ensure continuously that authority and responsibility are being properly delegated and exercised at all levels within the hospital and that no minor dictators are arising in departments of the hospital to the detriment of its work. ■

Plan Puts Supplies Where Patients Are

(Continued From Fold-Out Page Opposite Page 78)

veyor in the floor service core. The storage conveyor, which will hold six trays, will make it possible for supplies to be received without the immediate presence of an attendant. It is, as Mr. Friesen points out, easier to coordinate machines than people.

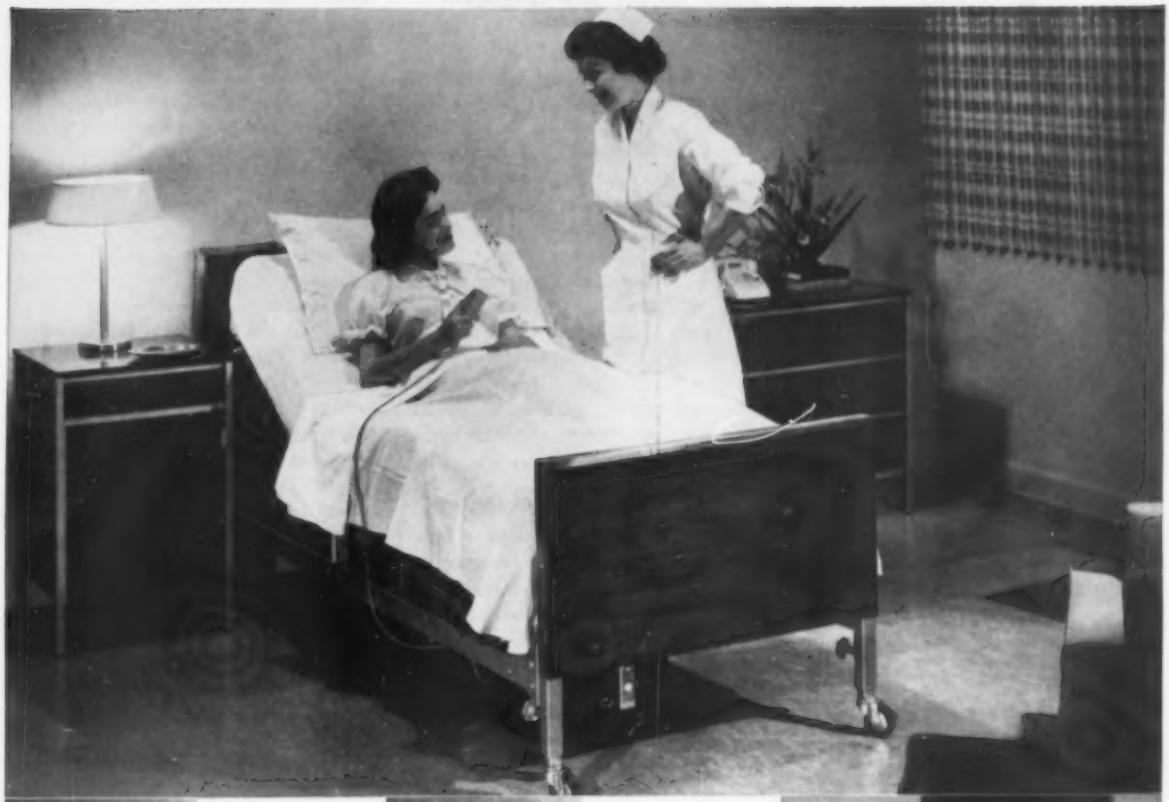
An entirely separate, conventional conveyor will be installed for "down service" to obviate any possibility of the sending unit's becoming contaminated by soiled materials.

Elimination of infection hazards has been a paramount concern of hospital officials, consultant and architects in designing the hospital. They agree with Dr. R. E. O. Williams, London authority on public hygiene, that "one of the most valuable contributions hospital administrators can make to the solution of cross-infection may well be the provision of really adequate isolation facilities in all wards sufficiently equipped to simplify the routine of isolation nursing." Hence the decision to make all rooms private (through they can be converted to double occupancy in case of need).

The need to reduce infection hazards to the irreducible minimum also determined the arrangement of the central clean-up and decontamination area of the dispatch center, which is illustrated and described in detail on the back of the insert. Mr. Friesen views with alarm the tendency in many hospitals to classify soiled objects as "ordinarily dirty" and "very dirty" – depending on the origin of the soil. Since public health authorities believe that there is more chance of cross-infection in undiagnosed cases than there is in those which are known to be infectious, Mr. Friesen considers it only logical to treat all soiled articles as if they were infectious.

The cost figures shown in the table on the front of the insert include the chapel and the Sisters' residence on the seventh floor. When occupancy of the hospital requires it, the residence can be changed to a patient floor.

Whatever automation adds to the usual construction costs, as Sister Mary Gerald points out, the investment will be returned in the savings in labor costs. Of far greater importance from the Sisters' point of view will be the benefits patients will derive because the nurses will have time to give them attention they need. ■



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When Nurses Are Negligent They Are Held Liable

(*Continued From Page* 91)

tablished by evidence of the inaction of the nurses in the presence of signals of danger which would have moved a reasonably intelligent attendant promptly to import a competent physician for the purpose of taking necessary precautions to prevent the development of the disease.

"For a supervisory nurse to permit a patient recovering from a major operation to suffer symptoms indicating a growing pathology for three days without medical care merely because attendant physicians were not available is a type of conduct that is negligent."[2]

Boundary Hard To Detect

Often difficult of detection however, is the boundary line between the conduct of the nurse which is the execution of the orders of the attending physician, for which he and not the nurse, is ordinarily responsible, and acts for which the responsibility is hers alone.

Such an incident was the subject of a controversy that was before the California courts for more than four years. There a hospital nurse was directed by a surgeon to prepare for a minor operation and told that he would need for a local anesthetic a 1 percent solution of novocain.

On a tray the nurse assembled various articles, a knife, forceps, sterilized towels, gauze, a syringe and similar equipment, but instead of the novocain she carelessly supplied a medicine glass of a four per cent solution of formalin.

Before operating the surgeon made a cursory inspection of the tray. Then, taking up the syringe he drew into it the liquid in the medicine glass and injected three or four drops into the vicinity of the cyst he was about to remove. While the jury in the action subsequently brought by this patient exonerated the physician a verdict was returned against both the hospital and the nurse individually.

In its distinction here between the liability imposed on the hospital and the nurse and the exoneration of the surgeon the court said of the law governing the circumstances in this instance:

"A physician is not liable for the negligence of a hospital, or their nurses, attendants or interns who are not his employes, if he has no knowledge thereof or has no connection therewith, or if it is not discoverable by him in the exercise of ordinary care, or unless he is negligent in permitting them to attend the patient.

"But it has been held that where a hospital nurse, although not in the regular employ of an operating surgeon, is under his special supervision and control during the operation, the relation of master and servant exists and that the surgeon is liable for the nurse's negligence."

Supporting its conclusion with this statement of the law the court added, "We think it plain from the evidence that the acts of preparation performed by the nurse were not done under the special supervision of the surgeon. On the contrary, as we have seen, they were performed in his absence.

"That they were done at his request or direction is not significant since she was merely attending to duties devolving upon her as an employe of the hospital, and whether performed by her at the direction of an officer of the hospital made in pursuance of a previous direction by the doctor or upon the request of the doctor made directly to her, cannot affect the legal situation."

Nurse Was Negligent

With this statement of the relative liability of the physician and the hospital, the court added, "This leaves for consideration the appeal of the nurse. It could hardly be contended that the nurse was not guilty of negligence in furnishing the surgeon a solution of formalin in place of the novocain requested.

"The evidence shows that the nurse was quite familiar with the characteristics of novocain and formalin, that she was in charge of the cabinet in the operating room in which they were kept and had been for nearly two years, that it was among her duties to replenish from time to time as necessary the drugs and other substances kept in the cabinet, among them novocain and formalin, which were contained in bottles, each labeled with the name of its contents.

"She accounted for her mistake by frankly admitting that she took no pains to read the label on the formalin bottle before pouring part of its contents into the medicine glass."[3] ■

[2]Valentin *v.* La Societe Francaise de Bienfaisance, 172 Pac. 2d 359, California, Sept. 6, 1949.

[3]Hallinan *v.* Prindle, 29 Pac. 2d 202, California, Feb. 1, 1934.

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NEWS DIGEST

Hospital Unionization Threat Discussed by A.H.A. Officials at Texas Meeting . . . Infections Program Described for Upper Midwest Group . . . Waukesha Medical Staff, Board Resolve Dispute . . . Schools Announce Administrative Residencies

Hospital Unionization Threat Discussed by A.H.A. Officials at Texas Hospital Meeting

HOUSTON. — The American Hospital Association is not anti-labor, but it is alarmed over the growing threat of unionization of hospitals, two officials of the A.H.A. explained in a discussion here at the 30th annual meeting of the Texas Hospital Association.

Fred Higginbotham, administrator of Baptist Memorial Hospital, San Antonio, was named president-elect of the state group at the convention.

"The union position is a perfectly defensible one," said Dr. Russell A. Nelson, "but not in the care of the sick in a nonprofit hospital. Union activity is usually against management and profits, but in a hospital, management doesn't suffer and there are no profits to suffer. The patient is the one who is hurt."

Unionization of hospitals, he added, would put substantial power over the operation of services to the sick in the hands of a special group dedicated to its own interests.

Dr. Nelson, A.H.A. president-elect, is director of Johns Hopkins Hospital, Baltimore.

James E. Hague, A.H.A. assistant director and executive editor of *Hospitals*, pointed out that the threat of hospital unionization is anything but a local problem. He said that threats of strike against hospitals are being made in Buffalo, N.Y.; Portland, Ore.; Fresno, Calif. and Denver.

The two association officials also made the following points:

— Higher salaries mean a substantial hike in patient day charges. An American Hospital Association study has shown that if hospital wages are increased so that no employe makes less than $1.25 per hour, the minimum payroll increase in the U.S. would be $3.15 per patient day.

— Unionization may hinder voluntary support of nonprofit hospitals. If this happens, the speakers warned, there can be only two alternatives: limited services to patients or government support.

The possibility of a strike by employes in Texas hospitals was minimized by Philip Overton, legal counsel for the Texas Hospital Association.

"Ninety per cent of these employes work in nonprofit hospitals and could simply be fired in case of organized labor disputes," he said. "The other 10 per cent work in privately owned hospitals."

Disenchantment with current Blue Cross practices in New Jersey underscored much of Anthony W. Eckert's presentation at a prepayment session. Mr. Eckert is president of the American College of Hospital Administrators and director of Perth Amboy Hospital, Perth Amboy, N.J.

"While I as an individual feel that Blue Cross gives me more in terms of hospital care for my payments than any other prepayment plan," he said, "I also feel that our New Jersey Blue Cross Plan is short-changing our hospitals."

Mr. Eckert said that Perth Amboy Hospital had cancelled its contract with New Jersey Blue Cross despite the fact that 54 per cent of the hospital's patients had this coverage.

He said that after nine months of operation without a Blue Cross contract, many unnecessary hospital admissions and much over-utilization had been eliminated.

"I personally believe," he said, "that hospital services are being over-utilized and abused."

In a report on the experience of Harris Hospital, Ft. Forth, with progressive patient care, Dr. Nealie Ross said that the hospital's 13 bed, critically ill unit was staffed each eight-hour

(*Continued on Page* 190)

Editorial Award Given to The Modern Hospital

CHICAGO. — An award for editorial excellence has been presented to The MODERN HOSPITAL by *Industrial Marketing* in its annual editorial achievement competition.

The award was for a series of 11 articles on the problem of infection in hospitals which appeared in the January 1958 issue and the March through December 1958 issues.

Otho Ball Award Given

CHICAGO. — Fred Hatcher Smith has been named recipient of the Otho Ball Memorial Fund postgraduate training award, given annually by the American College of Hospital Administrators. Mr. Smith, who is currently completing requirements for his graduate degree in hospital administration from Washington University, plans to serve his extended residency at Barnes Hospital, St. Louis, where he has been undertaking his required year of residency training.

Describe Program of Infections Committee For Upper Midwest Hospital Conference

ST. PAUL.—An infections committee should be directed by a properly qualified physician with the support of bacteriological consultation, David A. Gee, associate director of Jewish Hospital, St. Louis, told an audience of 2400 at the 12th Upper Midwest Hospital Conference, May 13 to 15 in St. Paul.

Mr. Gee was one of a panel of three from the hospital who presented the major general session of the conference. By request of the participants, all section and special meetings were suspended Thursday morning to hear the program on "Organization and Operation of a Hospital Staphylococcal Program."

The successful design and implementation of the Jewish Hospital operation was described by Dr. Kenneth Serkes, associate in surgery, and Alex Sonnenworth, hospital bacteriologist, as well as by Mr. Gee.

The first year of the Jewish Hospital program will cost about $87,000, Mr. Gee said, and subsequent annual costs will be about $44,000, amounting to a per patient day additional cost of about 50 cents. He stressed the importance of an active and interested board of directors in backing the program, which ranges from a greatly expanded employe health service to new isolation procedures for patients, all involving an active educational and supervisory program.

Other general sessions in the conference, which attracted a total of 4700, concerned care of the chronic and aged, prepaid medical and hospital care, and progressive patient care.

Two Canadians, Dr. F. B. Roth, deputy minister in the Saskatchewan public health department, and Stanley W. Martin, secretary-treasurer of the Ontario Hospital Association, described the development of provincial health care plans. "Public acceptance (of Saskatchewan's tax supported hospital plan) has been enthusiastic from the start," Dr. Roth said, but "acceptance by hospitals and the health professions was slower to develop. It is my candid and honest opinion," he added, "that the hospitals, the medical, nursing and other health professions are now firm and even enthusiastic supporters."

Robert M. Sigmond, executive director of the Hospital Council of Western Pennsylvania, outlined a program which voluntary hospitals might follow in strengthening the role of voluntary prepaid insurance.

He urged leadership by hospitals themselves in developing effective plans to meet community needs, on the premise that "the future of voluntary hospitals will be largely determined by current developments in the extension of group payment."

Harold C. Mickey, (left) past president of the Upper Midwest Hospital Conference and newly elected president, Richard Lubben.

Richard Lubben, administrator of Bozeman Deaconess Hospital, Bozeman, Mont., succeeded Harold Mickey of Rochester Methodist Hospital, Rochester, Minn., as president of the regional conference. New president-elect, to take office in 1960, is J. E. Robinson, superintendent of Children's Hospital of Winnipeg, Winnipeg, Manit.

A.C.H.A. Begins Drive For $375,000 Fund

CHICAGO. — A $375,000 fund is being sought by the board of regents of the American College of Hospital Administrators in a campaign headed by Dr. Fraser D. Mooney, director of Buffalo General Hospital, Buffalo, N.Y.

The A.C.H.A. is seeking the money from voluntary contributions to finance continuation of preceptors training and a revision of the residency manual; a Regents Resources Fund; research; scholarships and loans, and exploratory educational conferences, the College announced.

Waukesha Medical Staff, Board Resolve Dispute On Specialists Contracts

WAUKESHA, WIS. — Compromise agreement has brought at least a temporary end to a proxy fight between Waukesha Memorial Hospital's medical staff and board of trustees over a bill pending in the state legislature. The bill would authorize hospitals to contract for the services of certain medical specialists.

The campaign by the medical staff to obtain proxy votes to unseat three members of the board of trustees arose after the board voted endorsement of the bill, 129A. The medical staff members claimed that they were not given an opportunity to present their views before the board and that they were not represented by the trustees.

The medical staff and the trustees finally confirmed these agreements:

1. Both parties agree to withhold further consideration or action on Bill 129A until the bill takes final form in the legislature or a ruling is received from the attorney general on the legality of present contracts between the hospital and certain specialists.

2. Any active campaign to solicit proxies by the board of trustees and medical staff will be temporarily suspended.

Bill 129A authorizes nonprofit hospitals to contract for services in radiology, pathology, physiatry and anesthesia. Robert M. Jones, administrator of Waukesha Memorial, said two radiologists, two pathologists, one physiatrist and one electrocardiographist are presently under contract at the hospital.

The board contended that the bill would only assure the legality of current practice and is the only practical way for hospitals to utilize these specialized services. An opinion was requested from the state attorney general on the legality of contracts now in effect at the hospital.

The 55 doctors on the hospital staff had contended that the bill constitutes fee splitting, jeopardizes the individual doctor-patient relationship, is the corporate practice of medicine, and could lead to socialized medicine.

The dispute had precipitated the resignation of Dr. H. F. Sydow as medical staff director and elicited an offer from Mr. Jones to resign as administrator.

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N.L.N. Votes To Control Accreditation Policy

(*Continued From Page* 92)

ciate degree programs. However, the members of the board thought it desirable for them to bring to the council of member agencies and the steering committee a resume of their thinking on this problem inasmuch as it involves the N.L.N.'s over-all relationship with another organization, which is the function and concern of the board."

This resume of the steering committee's thinking led to the revised statement on accreditation policy that was overwhelmingly approved at the special session preceding the League's biennial convention.

Convention Activities

The firmness of purpose demonstrated by the League in its approach to nursing accreditation was emphasized in her presidential address by Miss Freeman, who equated it with a new maturity for the League.

"The confidence we feel in our values," she said, "leads us to greater acceptance of different values in others. We move without fear or hostility to joint efforts with organizations who see things differently. We can recognize the stake of the American Hospital Association in accreditation of hospital schools of nursing, and accept the fact that the purposes and direction of that organization may lead them to different concepts of that function. This base of understanding permits fruitful action in spite of our differences."

It was obviously this base of understanding to which Miss Freeman referred when, at the last business meeting of the convention, she told the membership that, despite differences of opinion between the N.L.N. and A.H.A., the hospital association, even at the time it passed its accreditation resolution, recognized the value of accreditation, the need for programs in nursing to be educationally sound, and the need for high accreditation standards. She told her audience that she believed that the A.H.A. action did not express lack of confidence in the League and certainly not in the accreditation program, but rather demonstrated a real concern of hospital administrators as to what share they might have in this over-all process of accreditation.

"A.H.A. members were concerned," she said, "partly with the problem of spreading the costs of nursing education which are, in many instances, passed on in terms of cost of the hospitalization to the patient. They wanted to see whether they could spread this cost over all of the hospitals rather than just over the hospitals that maintain schools of nursing."

On Diploma Programs

Whether related or unrelated to the hospital association concern for the future of diploma programs in nursing, the approval in principle at this convention of a statement of belief concerning these programs by members of the department of diploma and associate degree programs should come as good news to those nurses in education and service and hospital administrators who have asked repeatedly for such an expression. The statement reads:

"Nursing in broad scope is a profession that employs persons with varying degrees of ability and preparation. There is a need for educational programs designed to prepare these persons. In order to assist in maintaining and increasing the number of registered nurses required to meet the expanding demands for nursing services, the N.L.N. believes that

educationally sound diploma programs in nursing offered by independent or hospital controlled schools are essential.

"Such diploma programs offer education in nursing which prepares graduates for general duty nursing positions in hospitals, nursing homes, and comparable situations and could form a basis for further study and for specialization if desired. Graduates of these programs are prepared to function as specified in the current criteria to utilize the understandings and to demonstrate the personal characteristics outlined therein." (This paragraph is approved on an interim basis until such time as it can be amplified so that it clearly sets forth the unique characteristics and values of the diploma program for prospective candidates, employers of graduates of diploma programs, and the public.)

Convention Planned

PARIS. — The sixth annual convention of Les Technicians de la Sante will be held at Exposition Park, Porte de Versailles, Paris, June 9 through 12. The program will include talks on hospital design, management and professional routine, with particular emphasis on construction and equipment.

Study Finds Three Areas Of Nurses' Discontent

NEW YORK. — Three main problem areas were identified as responsible for an abnormal rate of nursing personnel turnover at a midwestern hospital, according to a study reported in a recent issue of the *American Journal of Nursing*.

The problem areas were: "the debilitating effects of understaffiing, the lack of an adequate communication channel between staff and management, and the absence of a clear definition of nursing roles and personnel policies.

"Several problems were closely related to the shortage of personnel throughout the hospital," the *Journal* reported. They included "floating," or shifting from ward to ward which prevents the formation of efficient, stable groups; interpersonal tensions arising among nurses who feel unable, by virtue of their limited numbers, to accomplish the work that must be done, and certain personnel policies such as the method of assignment of days off, the study found.

"More than one-half of the nurses surveyed indicated some confusion about their professional roles. There seemed to be a discrepancy between the hospital's expectations of the nurse and her own view of the functions that she should perform. The nurses felt that . . . such nonnursing tasks as clerical work and transporting equipment were performed at the expense of patient care. This discrepancy between the 'ideal' and the 'actual' professional role was frustrating," the *Journal* article said.

The nurses' suggestions for improvement included hiring more clerical assistants. They also felt that inservice education for nursing aides and housekeeping personnel would prepare those auxiliary workers for efficient functioning on the wards. Nurses would then be free to spend more time with their patients, the survey showed.

Extends Nursing Course

NEW HAVEN, CONN. — Extension of the present one-year graduate course of study to two years at the Yale University school of nursing has been announced by Florence S. Schorske, dean of the school. The curriculum revisions are in public health nursing, maternal and newborn nursing, and mental health and psychiatric nursing.

Warns of Regulations for Mailing Analysis Samples

CHICAGO. — Insufficient postage on many cylindrical parcels containing blood, urine and laboratory samples sent by physicians to hospitals, health departments, clinics and so forth means that they may be delayed or lost, the U.S. Post Office here warned.

Many hospitals and laboratories to which such materials are sent will not pay postage due on specimens sent to them for analysis, the postal authorities said.

Containers with insufficient postage will not be returned unless the sender's complete address and the inscription "Return Postage Guaranteed" are shown in the upper left corner on the outside of the address label. The officials said many such parcels contain the sender's name on the inside only, and thus are sent to the dead letter office.

The Third Class rate for odd shaped and cylindrical containers is 3 cents for the first 2 ounces and 1½ cents for each additional ounce or fraction. A minimum rate of 6 cents is charged on all such parcels. Thus any tube weighing less than 4 ounces must have 6 cents postage.

Two Radiologists Suspended in New York

BINGHAMTON, N.Y. — Two top radiologists were suspended by Binghamton City Hospital on grounds that they had falsified records of radiation given a cancer patient who died of radiation burns, the Associated Press reported May 12.

According to the report, the board said that the two radiologists originally filed an accurate version of the treatments but later substituted an account that alleged that proper doses had been given.

Cleveland Council Elects

CLEVELAND. — Edwin W. Miller, director of Huron Road Hospital, has been elected president of the Cleveland Hospital Council, succeeding Stanley A. Ferguson, director of University Hospitals, who had been president for the last five years. Other newly elected officers are: first vice president, Theodore Thoburn, president of St. Luke's Hospital; second vice president, Sidney Lewine, director of Mt. Sinai Hospital, and treasurer, Michael Wach, Cleveland Board of Education.

Western Program Features Lecture on Leadership

(*Continued From Page 73*)

were put on the record by George U. Wood, executive vice president of the Peralta Hospital, Oakland, Calif., who was impressed with the quality of medical care that was evident in the hospitals he visited on a tour of Russia last fall. Patient accommodations were austere by our standards, Mr. Wood said, but the hospitals he visited were well equipped professionally, and the doctor-patient relationship was not visibly affected by the fact that the 360,000 practicing physicians in the U.S.S.R. are all employes of the Ministry of Health.

Some technics differ from ours, Mr. Wood reported. For example, he visited one huge operating room where three operations – a gastric resection, a gallbladder and a hernia – were being performed simultaneously by women surgeons. There were 67 people in the operating room at the time, Mr. Wood said.

Notwithstanding this and other practices we might call bizarre, Mr. Wood reported an over-all impression of high quality medical care. "Their equipment is good," he concluded. "Their setup exemplifies progressive medicine and surgery and public health activities."

At a convention session on nursing, the dogma of the nursing intellectuals

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Top: Mayor Richard J. Daley (left) greets John W. Rankin, president of the Tri-State Hospital Assembly. Center: Adiel Stewart, mayor of Salt Lake City (right) with Prof. James A. Hamilton, University of Minnesota, at the Association of Western Hospitals meeting. Bottom: Mayor Roe Bartle of Kansas City, Mo., (left) at Mid-West Association banquet. James Carr of Casper, Wyo., the retiring president, is shown at right.

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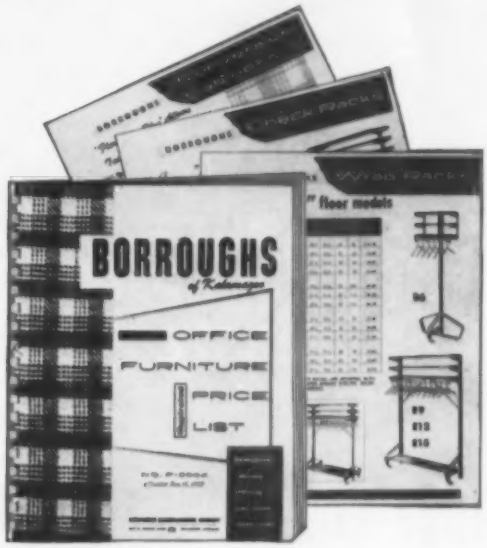

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was rejected by one of nursing's leading intellects – Eleanor C. Lambertsen, secretary of the American Hospital Association's nursing committee, who championed the diploma schools in a panel discussion that also included representatives of the practical nurse, junior college, and college programs.

"The faculty in the university is out of touch with reality in nursing," Miss Lambertsen said, attacking the intellectuals' position that nursing education belongs in educational institutions rather than in hospitals. The faculty in a diploma school, in contrast, is "deeply enmeshed" in the hospital all the time, she pointed out.

The nurse needs preparation in four areas, and the hospital is the proper environment for teaching all the needed skills, including competence in practice, communications, human relations, and the application of scientific principles to nursing, Miss Lambertsen concluded.

Clyde W. Fox, administrator of the Washoe Medical Center, Reno, Nev., was named president-elect of the association at the annual business meeting. Mr. Fox will succeed Wesley G. Lamer, Physicians and Surgeons Hospital, Portland, Ore., who became president during the convention. Ralph J. Hromadka, Santa Monica Hospital, Santa Monica, Calif., was the retiring president.

Other officers elected were Thomas P. Langdon, San Francisco, and Ray Woodham, Albuquerque, N.M., vice presidents; and Clifton H. Linville, Fresno, Calif., treasurer.

Left: Rex von Krohn, Josephine General Hospital, Grant's Pass, Ore., appeared in western dress at the Western hospital meeting to celebrate Oregon's centennial. Right: James McAlvin, administrator, Anaheim (Calif.) Memorial Hospital.

Ray Brown Talks Strategy to Federal Administrators

CHICAGO. – Strategy is an essential element in the art of administration and the successful administrator knows and uses a dozen or more different kinds of strategy, singly or in combination, as the problem or situation may demand.

The nature of strategy in hospital administration was described by Ray E. Brown, superintendent of the University of Chicago Clinics and past president of the American Hospital Association, at a dinner for federal hospital administrators during the Tri-State Hospital Assembly here last month.

Strategy is simply the chosen method for implementing decisions and producing action, Mr. Brown told 300 administrators attending the dinner, and it may be separated from other elements of the art of administration, such as judgment, climate and common sense.

Among the kinds of administrative strategy described by Mr. Brown were the following:

1. The strategy of timing or "opportuneness," or choosing the precise moment at which to act.

2. The strategy of decisiveness or confidence; acting with authority even when some uncertainty about the course of action may exist.

3. The strategy of ambiguity, or withholding the commitment until the moment of action arrives.

4. Strategy of obliqueness, or proceeding by indirection.

5. Choice of the least controversial approach.

6. Compromise or integration.

7. The strategy of flexibility, leaving the administrator room in which to maneuver.

8. Simplification, or elimination of tangential factors.

9. The strategy of "underbuilding," or keeping expectations within reasonable limits.

10. The strategy of involvement, getting people in the organization involved in a course of action, though not participating in the decision.

11. Confirming the commitment.

12. The strategy of the "hidden hand," or having someone other than the administrator lead.

These and other strategies are characteristic of administrative behavior and essential to the art of administration, Mr. Brown concluded.

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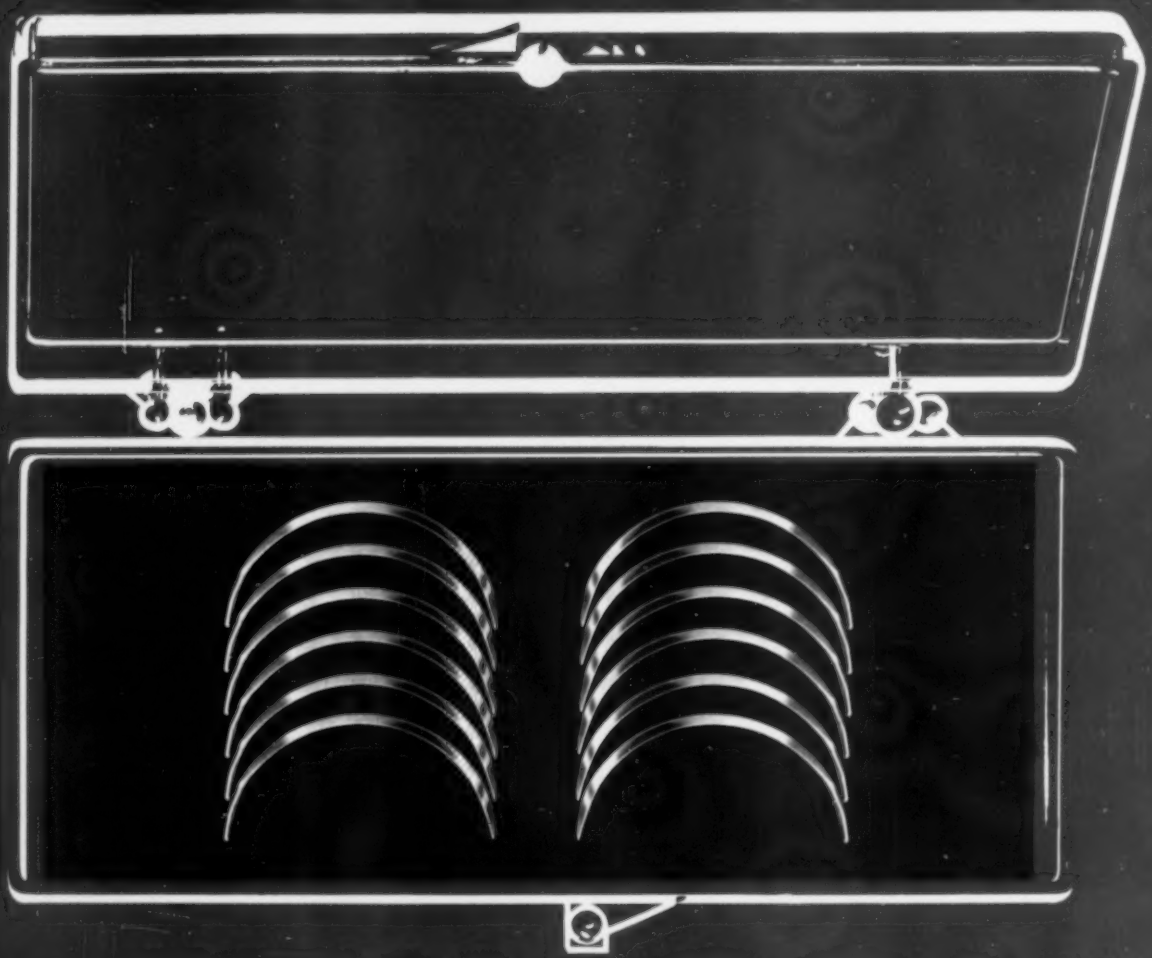

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AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Radisson Hotel, Minneapolis, Oct. 12-15.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Convention and Annual Meeting, New York, Aug. 23-26.

AMERICAN DIETETIC ASSOCIATION, Shrine Auditorium, Los Angeles, Aug. 25-28.

AMERICAN HOSPITAL ASSOCIATION, The Coliseum, New York, Aug. 24-27.

AMERICAN MEDICAL ASSOCIATION, Convention Hall, Atlantic City, June 8-12.

ARIZONA HOSPITAL ASSOCIATION, Monte Vista Hotel, Flagstaff, Oct. 8, 9.

COLORADO HOSPITAL ASSOCIATION, The Antler's Hotel, Colorado Springs, Oct. 8, 9.

COMITE DES HOPITAUX DU QUEBEC, Montreal Show Mart, Montreal, Que., June 24-26.

HOSPITAL ASSOCIATION OF RHODE ISLAND, Sheraton-Biltmore Hotel, Providence, Oct. 1.

IDAHO HOSPITAL ASSOCIATION, Elks Lodge, Boise, Oct. 19, 20.

JOINT COUNCIL TO IMPROVE THE HEALTH CARE OF AGED, Sheraton Park Hotel, Washington, D. C., June 12-14.

MARYLAND-D.C.-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D. C., Oct. 26-28.

MICHIGAN HOSPITAL ASSOCIATION, Sheraton Cadillac Hotel, Detroit, June 21-23.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Buena Vista, Biloxi, Oct. 7-9.

NATIONAL REHABILITATION ASSOCIATION, Boston, Oct. 26-28.

NEW HAMPSHIRE HOSPITAL ASSOCIATION, Mountain View House, Whitefield, June 18, 19.

NORTH CAROLINA HOSPITAL ASSOCIATION, Mayview Manor, Blowing Rock, June 10-12.

OREGON ASSOCIATION OF HOSPITALS, Coos Bay, Oct. 19, 20.

SASKATCHEWAN HOSPITAL ASSOCIATION, Bessborough Hotel, Saskatoon, Oct. 14-16.

Pharmacists Elect Colina

ATLANTA. — Gilbert Colina, chief pharmacist of Mercy Hospital, Charlotte, N.C., was installed as president of the Southeastern Society of Hospital Pharmacists at its annual meeting here recently. Others taking office were: vice president, Perry E. Cox, Birmingham, Ala., and secretary-treasurer, Mary Wernersbach, Miami Beach.

A.H.A. Officials Discuss Hospital Unionization

(*Continued From Page* 176)

shift with four registered nurses, one practical nurse, and one nursing aide. Charges are $35 per day in the unit, said Dr. Ross, a member of the hospital's medical board.

Sister Mary Helen, administrator of St. Paul Hospital, Dallas, reported that 20 per cent of the hospital's patients are eligible for the self-help unit. Charges per day at the hospital, she said, are $11 in the self-help unit; $18 in the intermediate unit, and $22 in the intensive care unit.

The future of disposables in hospitals continues to be bright, panelists agreed, although they are a mixed blessing to institutions concerned with an economical operation.

Ray E. Brown, superintendent of the University of Chicago Clinics, listed three criteria for evaluating reusables and disposables.

1. Comparable costs. These are difficult to obtain, he said, because they should include both avoidable and unavoidable costs. Too often, he said, hospitals take on the added expense of disposables without a compensating reduction in the payroll.

2. Degree of quality control. A manufacturer producing a large volume can usually control quality better than a small volume producer, he said.

3. Inventory control. Disposables require more storeroom space, material handling, and operating funds, he said. Controlling thievery and the volume of an item used are also more difficult with disposables, he pointed out.

The four-day meeting, held May 11 through May 14, attracted more than 3600 guests. A convention feature was the first session of the newly organized house of delegates of the Texas Hospital Association. In addition to President-Elect Fred Higginbotham, officers elected included: Sister Mary Vincent, administrator, Santa Rosa Hospital, San Antonio, vice president; Albert H. Scheidt, Parkland Memorial Hospital, Dallas, treasurer.

To Be Medical Center

DALLAS. — Change in name of Baylor University Hospital, Dallas, to Baylor University Medical Center of Dallas was announced recently by W. R. White, president of Baylor University. The center comprises a medical and surgical hospital, women and children's hospital, and a teaching and research hospital.

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COLUMBIA UNIVERSITY HOSPITAL ADMINISTRATION STUDENTS

Columbia Announces Hospital Residencies

NEW YORK. — Students in hospital administration at Columbia University school of public health and administrative medicine have been appointed to the following residencies:

Paul F. Avard to Somerset Hospital, Somerville, N.J.; James A. Buffington to Hunterdon Medical Center, Flemington, N.J.; Thomas P. Callaghan to Hackensack Hospital, Hackensack, N.J.; Hyman Cohen to Long Island College Hospital, Brooklyn, N.Y.; Stephen L. Forstenzer to Hospital of the University of Pennsylvania.

William G. George to Ellis Hospital, Schenectady, N.Y.; William A. Hurlburt to Muhlenberg Hospital, Plainfield, N.J.; Arthur J. Jarvis to Danbury Hospital, Danbury, Conn.; Raymond M. Jefferson Jr. to U.S. Public Health Service Hospital, Stapleton, Staten Island, N.Y.; Robert L. Judy to Jefferson Medical College and Medical Center, Philadelphia.

Marvin B. Klein to Lebanon Hospital, New York; Harry E. Landbo to Palo Alto-Stanford Hospital Center, Palo Alto, Calif.; Otto E. Lynch to Jackson Memorial Hospital, Miami; Maurice I. May to Barnert Memorial Hospital, Paterson, N.J.; Francis J. Murphy to Community Hospital, Glen Cove, Long Island, N.Y.; Victor M. Pietri to Bayamon District Hospital, Bayamon, Puerto Rico, and Veterans Administration Center-San Patricio, San Juan, Puerto Rico.

Robert R. Reidy to Mount Auburn Hospital, Cambridge, Mass.; Juan Rivera-Rivera to Veterans Administration Center-San Patricio, San Juan, Puerto Rico, and Bayamon District Hospital, Bayamon, Puerto Rico; Dr. Abraham Rossman-Castilla to Herrick Memorial Hospital, Berkeley, Calif.; Leonard Schrager to Montefiore Hospital, New York; Irwin Shapiro to Hospital for Joint Diseases, New York, and Hiram Yunque-Martinez to Bayamon District Hospital, Bayamon, Puerto Rico.

University, Hospital Merge

BOSTON. — The informal cooperative arrangement that has existed between Boston University and Massachusetts Memorial Hospitals has been converted to a formal association with the formation of Boston University-Massachusetts Memorial Hospitals Medical Center, it was announced here in May.

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Miami — Superior Linen Co.
W. Palm Beach — Hotel & Apt. Supply Co.
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Atlanta — American Ass. Cos., Inc.; H. Baker Linen Co. of Ga.; Will Ross, Inc.
Chamblee — American Hosp. Sup. Corp.
Griffin — Southeastern Tex. Corp.; United Cotton Goods, Inc.
ILLINOIS
Chicago — The Burrows Co.; Clark Linen & Equip. Co.; Corco Textiles & Furn. Co.; Debs Hospital Supply; Jamieson Inc.; Leo's Fabrics; Karoll's Inc.; Walter H. Mayer & Co., Inc.; Mills Hospital Supply Co.; Morton Textiles, Inc.; Albert Pick Co., Inc.
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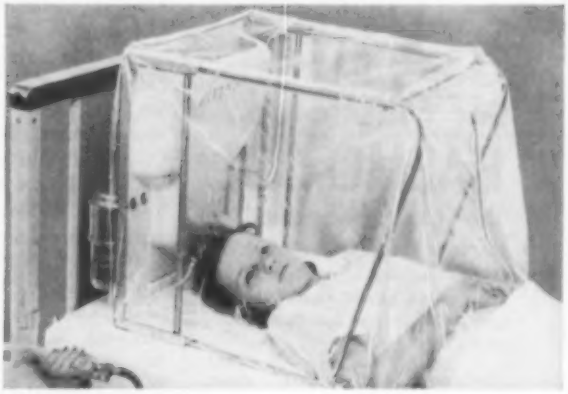

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ST. LOUIS UNIVERSITY HOSPITAL ADMINISTRATION STUDENTS

St. Louis University Lists Administrative Residents

ST. LOUIS. — Administrative residencies have been assigned to students in hospital administration at St. Louis University as follows:

Sister M. Ambrose Albers to St. Francis Hospital, LaCrosse, Wis.; Sister M. Vivian Bierschbach to St. Mary's-Corwin Hospital, Pueblo, Colo.; Sister Ruth Marie Bolton to St. Vincent Charity Hospital, Cleveland; Sister M. Hildalita Brake to Santa Rosa Hospital, San Antonio, Tex.

Sister Jeanne Marie Braun to Sacred Heart Hospital, Yankton, S.D.; Sister Mary Assumpta Buckley to Loretto Hospital, Chicago; Anthony Louis Bunker to City Hospital, St. Louis; Sister Peter Mary Cabrey to St. Vincent's Hospital, New York; Sister M. Helen Louise Deeken to Good Samaritan Hospital, Dayton, Ohio; Sister M. Canisia Gerlach to St. Vincent's Hospital, New York.

Sister Mary Laura Gunn to St. Joseph's Hospital, Syracuse, N.Y.; Sister Regina Mary Hanlon to St. Vincent Hospital, Worcester, Mass.; Sister M. Leonoris Henke to Providence Hospital, Detroit; John Homjak to Methodist Hospital, Memphis, Tenn.; Luther Ihle to St. Mary's Hospital, Grand Rapids, Mich.; Sister Philomene Ihle to St. Francis Hospital, LaCrosse, Wis.; Paul Irwin to Little Company of Mary Hospital, Evergreen Park, Ill.; Sister Mary Thomas Jirauch to Sacred Heart Hospital, Yankton, S.D.

Sister M. Weneburga Kaeuper to Good Samaritan Hospital, Cincinnati; Joseph Karonovich to St. Mary's Hospital, Duluth, Minn.; Sister Marie de Pazzi Lynch to Hospital of St. Raphael, New Haven, Conn.; Daniel Lawrence McAllen Jr. to Chanute Air Force Base, Rantoul, Ill.; John McAvinn to Lynn Hospital, Lynn, Mass.; Sister Maureen McDonald to St. Mary's Hospital, Grand Rapids, Mich.; Sister Verenice Mary McQuade to Mt. Carmel Hospital, Columbus, Ohio; Sister Angela Clare Moran to St. Vincent's Hospital, Erie, Pa.

Sister Maria of Providence Moran to St. Elizabeth's Hospital, Elizabeth, N.J.; Sister M. Fridoline Multhaup to St. Elizabeth's Hospital, Elizabeth, N.J.; Sister Anne Mary O'Donnell to St. Mary's Hospital, Waterbury, Conn.; Sister Alma Corde Schnellinger to Carney Hospital, Boston; Sister Mary Baptist Simon to St. Francis Hospital, Hartford, Conn.; Sister Mary Patrice Sinnott to St. Francis Hospital, Hartford, Conn.; Sister Peter Claver Thomas to St. Elizabeth Hospital, Brighton, Mass., and Sister Mary Regis Waszak to St. Elizabeth's Hospital, Dayton, Ohio.

N. Y. Blue Cross Elects Bugbee, Three From Labor

NEW YORK. — Three representatives of labor and George Bugbee, president of Health Information Foundation, have been elected to the board of directors of Associated Hospital Service, New York's Blue Cross plan, the group has announced.

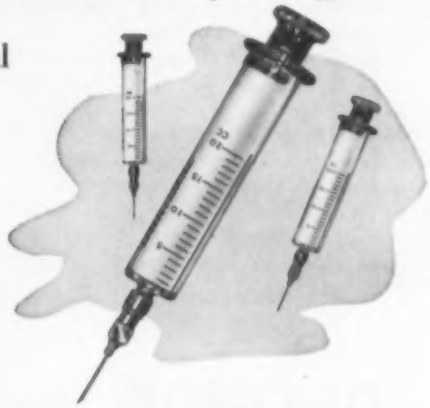
The labor representatives are Thomas Carey, business manager of District 15, International Association of Machinists, A.F.L.-C.I.O.; Louis Hollander, a vice president of the Amalgamated Clothing Workers of America and manager of the New York Joint Board, and Charles S. Zimmerman, a vice president of the International Ladies Garment Workers Union and general manager of its Dressmakers Joint Council.

Mr. Bugbee is a member of the board of directors and chairman of the master plan committee of the Hospital Council of Greater New York and a member of the hospital facilities research study section of the National Institutes of Health.

How Not to Get Stuck with Syringes

A report on the Economical stocking of Hypodermic Syringes by the hospital

by Alfred A. Mannino
EXECUTIVE DIRECTOR, HOSPITAL DEPT.
McKESSON & ROBBINS, INC.



Hypodermic syringes are high on the hospital pharmacy list of inventory "troublemakers." The following questions and answers are designed as a guide to make your syringe inventory operation as economical, and therefore profitable, as possible.

1. Should I buy disposable syringes or re-usable syringes?

To answer this question, you must determine the exact costs involved in rendering a glass hypodermic syringe usable after each use, including the available help on the floors as well as in Central Supply, and also the cost of processing a purchase order.

2. How much does it cost to buy hypodermic syringes?

Several studies show the cost of processing a purchase order to be anywhere from $4-$14. Procurement costs consist of the time and money spent in replenishment studies, purchase actions, receiving stock, inspecting stock and, of course, paying for stock. You can reduce procurement costs by placing fewer orders and buying larger quantities, but there is a direct proportion between procurement costs and carrying costs. Placing fewer and larger orders automatically increases carrying costs.

3. How much does it cost to stock hypodermic syringes?

Carrying costs consist of elements such as storage, obsolescence, loss through theft or damage and deterioration. Many industrial concerns calculate annual carrying costs at between 10% and 30% of the initial cost. Since the average hospital uses 10¢ per bed per day of syringes, obviously even a minimum 10% carrying cost will affect operating costs and, thus, profit.

4. How does the value of orders determine total costs?

Value of Order	No. of Orders Per Year	Procurement Costs	Average Active Inventory	Carrying Costs	Total Cost
$ 1200	1	$ 4	$ 600	$ 60	$ 64
600	2	8	300	30	38
400	3	12	200	20	32
300	4	16	150	15	31*
240	5	20	120	12	32
200	6	24	100	10	34

*Least Total Cost

5. When should I buy hypodermic syringes?

Many buyers ask, "How many syringes should I buy?" The real problem is not so much *how many* but *when* to buy. The when, of course, will also answer the question of how much. After your total costs of procuring and carrying are established, the resulting data will give you the economic purchase order quantity, or the number of times per year an order should be placed.

6. What is the economic purchase order quantity?

Economic purchase order quantity is the level at which the combined costs of procuring and carrying inventory are at a minimum. The size of the order which produces this result is known as the Economic Purchase Order Quantity.

7. What is a desired "Stock Turnover" as related to syringes?

Stock turnover is calculated by dividing the cost of sales by the cost of inventory. For example, if your cost of sales is $40,000 and your cost of inventory is $10,000, you are getting 4 stock turns per year. If, however, you wish to achieve a desired stock turnover of 5 per year, then $40,000 divided by 5 ($8,000) should be cost of inventory. The desirable stock turnover depends upon the value of the order, as shown in the chart under question #4.

8. How can McKesson & Robbins help alleviate your syringe problems?

With smaller inventories naturally comes the greater volume of turnover necessary for profitable operations. McKesson & Robbins Hospital Service Department helps make smaller inventories possible through its fast delivery service. With 82 warehousing units located strategically throughout the country, a local source of supply is available any hour of day or night for emergency deliveries as well as routine service.

In addition, McKesson offers its own outstanding line of hypodermic syringes and needles, as well as other pharmaceutical items. McKesson is now offering an invaluable free booklet entitled, "How to Prolong the Life of Hypodermic Syringes." We would be pleased to send it to you, as well as the name of the McKesson Hospital Service Department nearest you. Your McKesson representative will be glad to discuss your business problems with you, as well as your syringe care, cleaning and maintenance problems—at no obligation. Address your inquiry to: A. A. Mannino, McKesson & Robbins, Inc., 155 East 44th St., New York 17, New York.

Pennsylvania Extends Blue Cross Coverage

PITTSBURGH. — Diagnostic services for outpatients will be provided under Blue Cross and Blue Shield contracts under new agreements that have been approved by state insurance commissioner Francis R. Smith, it was announced here last month.

The additional charge for outpatient diagnostic coverage will range from 15 cents a month for individuals to 40 cents a month for families, the announcement said. Of these amounts, 4 cents to 13 cents applies to Blue Cross outpatient diagnostic coverage, and 11 to 27 cents is for the Blue Shield services, it was explained.

"Blue Cross will pay for services rendered and billed by the hospital, and Blue Shield covers such services outside the hospital when performed and billed by doctors," the announcement said.

Outpatient diagnostic services included under the new agreements include x-ray, electrocardiographic and electroencephalographic examinations, and basal metabolism tests, it was reported.

Action by Commissioner Smith in approving the new agreements was described as "an important forward step in meeting the public need and desire for comprehensive health care protection" by William H. Ford, Blue Cross president.

"The addition of outpatient diagnostic benefits will not only help eliminate the incentive for unnecessary inpatient hospitalization," Mr. Ford said, "but should help bring about early care that is important in conserving good health. In many cases, this should serve to avoid long and costly hospital stays often necessitated after illness reaches an advanced stage."

ABOUT PEOPLE

(*Continued From Page* 100)

Tasker K. Robinette, western regional manager for Consultant Associates Corporation, has been named administrator of Quincy Valley Hospital, Quincy, Wash. The hospital is under construction and is scheduled for July completion. Mr. Robinette is a graduate of the hospital administration course at St. Louis University. He previously had been stationed at Fairchild Air Force Hospital, Spokane, Wash.


Capt. C. M. Sanders

Capt. Charles M. Sanders has been appointed medical services administrator at the air force's newly constructed School of Aviation Medicine and Research Center, San Antonio, Tex. He is a graduate of the program in hospital administration at the National Naval Medical Center, Bethesda, Md., and the program in hospital administration at Georgia State College of Business Administration.

A. L. Joiner, business manager of Eugene Wuesthoff Memorial Hospital, Rockledge, Fla., has resigned. He has been succeeded by **E. Gilbert Slatton** as administrator. Previously Mr. Slatton had been administrative assistant at Tampa General Hospital, Tampa, Fla.

James A. Fox, formerly administrator of Sullivan County Memorial Hospital, Milan, Mo., has assumed his new position as administrator of Excelsior Springs Hospital, Excelsior Springs,

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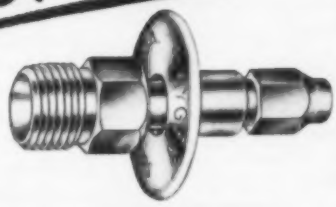

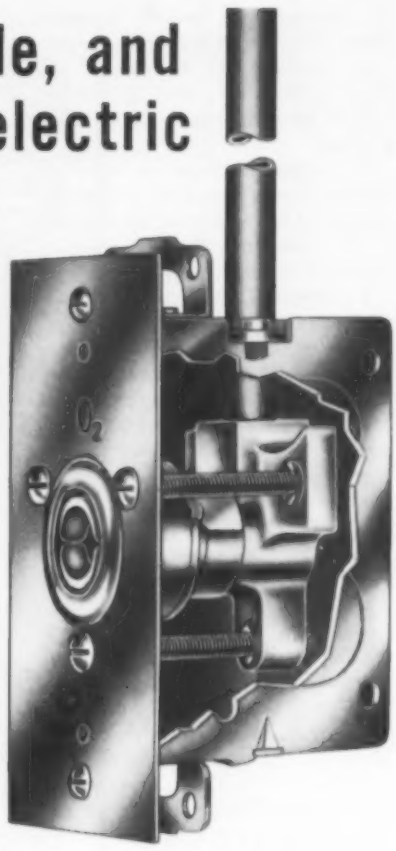

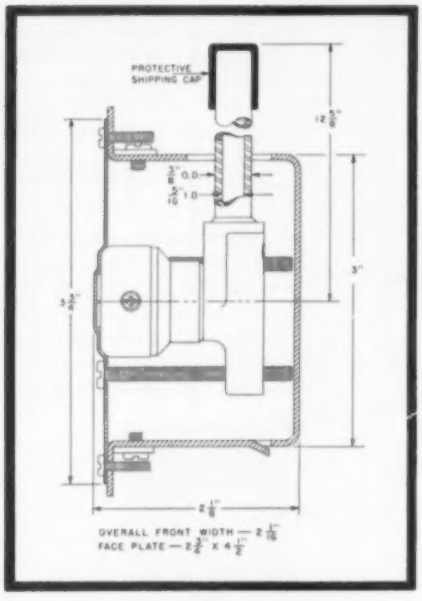

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Mo. He succeeds the late **Margaret Sharp,** who was killed in an ambulance accident last December. Mr. Fox has been succeeded at Sullivan County Memorial Hospital by **Clive Freeland.**

R. L. Groff has been appointed superintendent of Community Memorial Hospital, Crawford, Neb. He was previously with the Pennsylvania Department of Public Welfare.

Dr. Edwin H. Cole has been named superintendent of South Mississippi Charity Hospital, Laurel, succeeding the late **Dr. J. P. Fatherree.** A graduate of Millsaps College, Jackson, Miss., Dr. Cole received his medical degree from Tulane University.

Arthur E. Shade III

Arthur E. Shade III has been appointed managing director of the Methodist Church Home, Cornwall, Pa. He is presently engaged with the New York state prepayment study being conducted by the school of public health and administrative medicine of Columbia University. Previously he was assistant administrator of the Manhattan Eye, Ear and Throat Hospital, New York. He is a member of the American College of Hospital Administrators.

Frank O. Salt has been appointed assistant administrator of St. Luke's Hospital, Spokane, Wash. He is a graduate of the hospital administration course of Medical College of Virginia. Previously he was assistant administrator at Porter Sanitarium and Hospital, Denver.

Dr. R. T. Stevenson has retired as administrator of Lake Wales Hospital, Lake Wales, Fla. **Clarence W. Miller,** assistant administrator for the last two years has been appointed administrator. Mr. Miller is a graduate of the U.S. Navy School of Hospital Administration, Bethesda, Md.

Dr. John B. McHugh, manager of the Veterans Administration hospital at Kansas City, Mo., has been transferred to the hospital at Wilkes-Barre, Pa. He succeeds **Dr. Walter S. Pugh,** whose new post was announced in The MODERN HOSPITAL last month. The V.A. also announced that **Richard G. Jones** has been transferred from Palo Alto, Calif., where he has been assistant manager, to be manager of the Hot Springs, S.D., center.

Department Heads

Helen Halloran has been named coordinator of public relations and public information for Holy Cross Hospital, Chicago. Mrs. Halloran attended St. Louis University where she completed a special course in hospital administration. She was formerly a staff consultant with the Catholic Hospital Association.

Susan L. Dunn has been appointed director of nursing service and nursing education at Methodist Episcopal Hospital, Philadelphia. Formerly Mrs. Dunn was associate director of nursing at St. Luke's Hospital, New York.

Dr. Arild E. Hansen, professor and chairman of the pediatrics department at the University of Texas Medical School, has been appointed research director at Children's Hospital of the East Bay, San Francisco, succeeding Dr. Irvine McQuarrie, who will remain as consultant.

Virginia Keller has assumed her duties as assistant director of the James Ward Thorne School of Nursing, Passavant Hospital, Chicago. She had been on the faculty of Presbyterian-St. Luke's School of Nursing, Chicago. She received her Bachelor of Science degree in nursing education and a master's degree in nursing education from Loyola University. **Marcia Minch** has been appointed social director for the Passavant school of nursing. She is a graduate of Illinois Wesleyan University. The hospital has also announced the appointment of **Dorothy Dowrie** to succeed **Constance Florian** as volunteer director.

Miscellaneous

Col. Inez Haynes

Col. Inez Haynes, retiring chief of the army nurse corps has been appointed general director of the National League for Nursing. Col. Haynes will join the N.L.N. September 1, succeeding **Anna Fillmore,** who has been named executive director of the Visiting Nurse Service of New York. Col. Haynes is a graduate of Scott and White Hospital School of Nursing, Temple, Tex., has her bachelor's degree from the University of Minnesota, and has done advanced work in administration and management at the Army Medical Service School. She is currently chairman of the Council of Federal Nursing Service.

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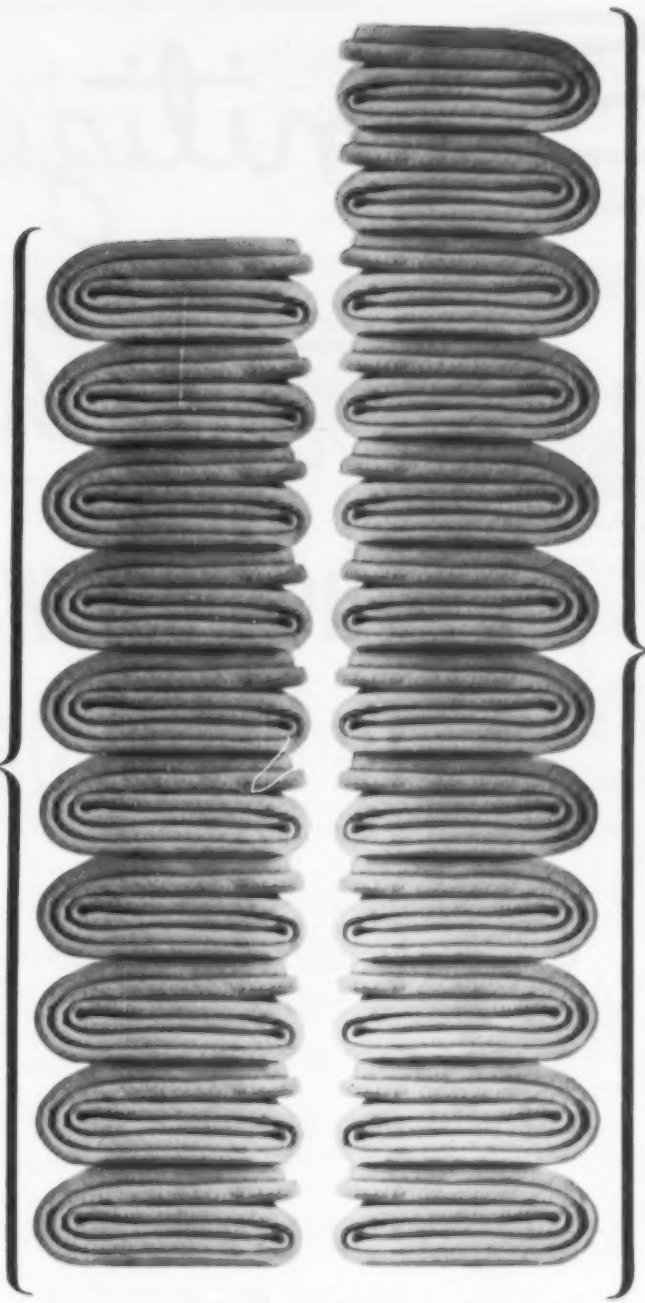

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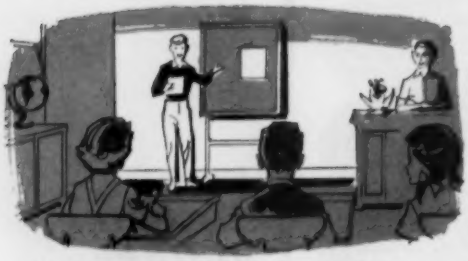

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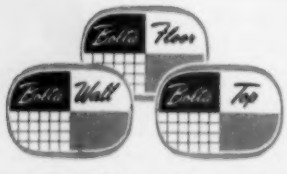

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ASSISTANT ADMINISTRATOR — B.S., presently completing work for MHA, leading university; seeks assistantship, hospitals 100-beds & up; will locate anywhere; age 28.

PERSONNEL DIRECTOR—Director, public relations; M.S., Political Science; LLB; excellent record of achievement.

RADIOLOGIST—Outstanding specialist, exceptionally well-qualified radiation therapy; many years, successful private practice, radiology; faculty member, member, medical school; Diplomate, both branches.

A & G MEDICAL PERSONNEL AGENCY
834 Second Street
Lancaster, Pennsylvania

ADMINISTRATOR or Assistant Administrator—B.S. degree in Psychology; graduate AF medical administrative school; at present administrator 180-bed AF Hospital and 2 years experience Commander 350-bed AF Hospital, military service terminates June 1959.

ASSISTANT ADMINISTRATOR — At present completing administrative residency, Masters of Business Administration, Graduate Program in Hospital Administration, Emory University, Atlanta, Georgia; available after June 30, 1959.

EXECUTIVE HOUSEKEEPER—Excellent background hospital and hotel experience; desires locate California or Ohio.

X-RAY TECHNICIAN—Male; at present heads technical laboratory performing EEG, vascular temperature test, cardiographs, BMR, audiometric studies, cardiac catherization, phonocardiogram and bronchial spriometric recorder; desires position offering further advancement in field.

SPEECH CORRECTIONIST—PhD degree; experience both in university and hospital clinics; specialty is cerebral palsy.

FOOD MANAGER—Male; B.S. degree in Hotel and Restaurant Administration; Pennsylvania State College; experience as manager for large restaurant chain and dietitian for Armed Forces.

HOSPITAL ENGINEER—Graduate University of Illinois; B.S. in Mechanical Engineering; Ohio State University, Master of Business Administration; Professional Engineering Registration, State of Massachusetts, requirements completed; a present supervising engineer for 906-bed hospital; during tour of duty with Air Force served as aircraft

A & G MEDICAL—Continued

maintenance engineer; member AHA engineering department; applicant has completed his training course and desires permanent position.

PHYSICIAN—Female; Ob-Gyn; wishes to locate Florida, California or other warm climate; 36 years, will accept salary or association.

SURGEON—Male; Board Eligible; available after July 1, 1959; wishes to associate with group, hospital, clinic or will serve small community.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland 15, Ohio

COMPTROLLER—12 years, 200-bed hospital; east or south preferred.

ASSISTANT ADMINISTRATOR—Age 36 years; M.H.A. Degree; 2 years administrative residency and assistant, 175-bed eastern hospital.

ASSISTANT DIRECTOR—M.S. Degree, Hospital Administration, 1951; 8 years experience, large hospital; desires east coast, or central states.

ADMINISTRATOR—A.B. Degree, 2 years assistant director, large Philadelphia hospital; 3 years superintendent, 150-bed hospital.

PURCHASING AGENT—20 years industrial and hospital experience; excellent references.

EXECUTIVE HOUSEKEEPER—Course in institutional housekeeping; 8 years, 300-bed Pennsylvania hospital; available.

SUPERINTENDENT—R.N.; 15 years nurse executive 40-85 bed hospitals; any location.

POSITIONS OPEN

ADMINISTRATOR—With proprietary hospital experience for 50-bed private hospital under construction, San Francisco Bay Area; position includes management of adjacent medical office building to be built soon and 50-bed convalescent facility; salary open. Apply MO 271, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ADMINISTRATOR—For 47-bed nursing home; fully experienced with management and personnel; salary open; live in; references required. Write details to Ocean View Rest Home, 88 Portland Road, Highlands, New Jersey.

ADMINISTRATOR—Qualified administrator for 77-bed hospital in Northern Ontario. Apply, stating qualifications, salary expected and previous experience to Mr. A. Jackel, Chairman, Board of Directors, Lady Minto Hospital, Cochrane, Ontario.

ANESTHETIST—Nurse; to complete staff of eight; 604-bed general hospital in northeast Ohio; salary open, generous employee benefits; no pediatric department; 40 hour week, plus overtime. Apply MO 272, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETIST—Nurse; in small rural hospital southwest area, approved J.C.A.H; one surgeon (F.A.C.S.); few OB's this is an ideal situation for an older anesthetist who does not desire to work too hard; but also ideal for one who enjoys small towns, and small hospitals; the salary is open and will be adequate, plus a bonus plan; state qualifications, salary desired and date of availability in first letter; hospital will pay travel expense for interview to proper applicants. Write MO 276, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

(Continued on page 202)

classified advertising

POSITIONS OPEN

ANESTHETISTS—Nurse; for 220-bed community hospital; working with private group; two full time M.D.'s, four nurses, all agents and techniques; modernization program going on; two and one-half hours from Boston and New York. Write G. J. Carroll, M.D., William W. Backus Hospital, Norwich, Conn.

ANESTHETIST—Lutheran Deaconess Hospital, a 200-bed general hospital located on the near Northwest side of Chicago is in need of an anesthetist for a permanent full time position beginning July 1, 1959; for details write to the Executive Director, Lutheran Deaconess Hospital, 1138 N. Leavitt Street, Chicago 22, Illinois.

ANESTHETIST—Nurse; 50-bed hospital soon to add 20 more; recently added a new modern nursing home (geriatrics) in conjunction with hospital; salary commensurate with experience, full maintenance; town in rich farm lands 85 miles from Chicago, population 6,000. Write Alvan A. Sauer, Administrator, Iroquois Hospital, Watseka, Illinois.

ANESTHETIST—Nurse; for 400-bed Joint Commission Accredited hospital; salary $490 per month, 40 hour week; many employee benefits. Apply Dr. R. Weyl, Anesthesiologist, Mount Sinai Hospital, California Avenue at 15th Place, Chicago 8, Illinois.

ANESTHETIST—Nurse; new 50-bed hospital; excellent working conditions and personnel policies. Contact Administrator, Dearborn County Hospital, P. O. Box 72, Lawrenceburg, Indiana. Phone 1010.

ANESTHETIST—Nurse; additional anesthetist wanted for new 1000-bed NP - VA Hospital with 161 GM&S beds; air conditioned operating rooms; ideal working conditions, sick leave, annual leave and life insurance benefits; salary depending on training and qualifications. Apply to Personnel Officer, VA Hospital, Topeka, Kansas.

ANESTHETIST—Nurse; for JCAH approved hospital; expansion program underway which will increase capacity from 165 to 240-beds; good personnel policies; salary $500.00 month for person with one or more years of experience, plus meals while on duty; extra pay for calls and overtime. Contact Administrator, W. A. Foote Memorial Hospital, Jackson, Michigan.

ANESTHETIST—Nurse; immediate openings in Minneapolis' finest hospital; salary commensurate with qualifications. Contact D. E. Baumgardner, Director of Personnel, St. Mary's Hospital, 2414 S. 7th Street, Minneapolis, Minnesota.

ANESTHETIST—Nurse; trained and experienced; graduate of approved nursing school with specialized training course in anesthesia; salary range $4750-$6178; paid vacation and sick leave; maintenance available for a single person. Apply Charles R. Walton, Personnel Director, New Jersey State Hospital, Trenton, New Jersey.

ANESTHETIST—Nurse-Director of Nurses; 26-bed general hospital; college town; no O.B. salary $500 to $600 per month. Apply Administrator, Crete Municipal Hospital, Crete, Nebraska.

ANESTHETIST—Nurse; immediate openings in fully accredited 300-bed general hospital for nurse anesthetist in city of 55,000 and serving area of 300,000 population; paid vacation and sick leave, social security and group hospitalization available. Reply stating education, experience, and salary requirements to Assistant Director, Lima Memorial Hospital, Lima, Ohio.

ANESTHETIST—Nurse; male or female; 100-bed modern hospital expanding to 150-beds, located in Columbia, Tennessee, which is 40 miles south of Nashville (20,000 population) base salary $480 per month, $10 per case for each case started after 3:00 p.m. Monday through Friday, all emergency cases Saturday and Sunday; minimum monthly guarantee $560; average monthly earnings $600; three weeks vacation, six holidays, social security and laundry of uniforms. For further details, contact W. B. Barnhart, Adminstrator, Maury County Hospital, Columbia, Tennessee.

ANESTHETIST—30-bed hospital; Board surgeon; near large town and shopping area; salary open. Apply MO 269, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIETITIAN—Assistant; A.D.A.; wanted in 400-bed hospital in Springfield, Missouri, "Ozarks Playground" salary $350.00 to $400.00 plus meals. Apply MO 270, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

(Continued on page 204)

With quick, convenient
Dixie* Medicine Cups in the
Dixie Dispenser, you get

NEW MEDICATION EFFICIENCY!

Medication for one patient or twenty is set up faster, administered more easily, with modern Dixie Medicine Cups. They're clean, feather-light to carry, disposable—and there's never the risk of broken glass. Imprinted (on the inside for added convenience) with milliliter, dram, fluid ounce, and teaspoon-tablespoon scales. 1-, 1½-, and 3-ounce sizes.

The Dixie Dispenser for 1-oz. Dixie Medicine Cups is smartly made of stainless steel and transparent, heavy-gauge plastic. Mounts easily, anywhere. Keeps cups fresh, always within handy reach.

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You can say goodbye to the costly, ugly, old-fashioned receptacle! Now, for every patient, an attractive, fresh Dixie Denture Container—always safe and clean! An important precaution that patients appreciate—another sure sign of the hospital that offers the most modern services!

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POSITIONS OPEN

DIETITIAN — Chief; Michigan; 140-bed Osteopathic Hospital. Apply MO 273, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIETITIANS—To work for food service company with operations in principal West Coast cities and Denver; formal 10 week training program followed by assignment involving full range of management activities; excellent opportunity for development and advancement; salary open. Reply to Food Service Management Division, Manning's, Inc., 901 Battery Street, San Francisco 11, Calif.

DIETITIANS—A.D.A.; very desirable positions available for therapeutic supervisors in hospital division of our progressive Industrial Food Service Company; forty hour week, two week vacation, two weeks sick leave, meals furnished, group hospitalization insurance available; top salaries; responsible for complete administration of patient food service; school of nursing. Apply Miss Rita Bedessem, Director; Hospital Division, Cooper Industrial Food Services, Inc., 5875 North Lincoln Avenue, Chicago 45, Illinois.

DIETITIAN—Position being created by opening of 120-bed rehabilitation addition to Iowa Methodist Hospital; excellent opportunity for ADA registered hospital trained person; possibility of work in either therapeutic or administrative areas; good pay, liberal benefits. Apply Personnel Director, Iowa Methodist Hospital, Des Moines 14, Iowa.

DIETITIAN—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Chief of department; A.D.A. member or eligible for registration; 90-bed hospital; liberal vacation, holidays and sick allowance; salary open. Contact Emil Wieland, Administrator, Jamestown Hospital, Jamestown, North Dakota.

DIETITIAN—Therapeutic; $5,000 beginning salary; exceptional opportunity for advancement—merit system; 503-adult bed, 72 bassinet general hospital. Apply Director of Dietetics Aultman Hospital, Canton 10, Ohio.

DIETITIAN—Staff; therapeutic; A.D.A. member, hospital recently expanded to 450-beds, located in residential district; approved by J.C.H.A.; dietary facilities entirely new and air-conditioned; dietetic program integrated with N.L.N. approved school of nursing, affiliated with Medical Research Institute, 40 hour week, broad personnel policies and benefits; salary open. Apply Miss Rosemary E. Brown, Director of Dietetics, The Toledo Hospital, Toledo 6, Ohio, or call Greenwood 2-1121.

(Continued on page 206)

CORNELL SUMMER PROGRAM DEADLINE EXTENDED

Applications for the Hospital Administrators Development Program at Cornell University, if made promptly, will still receive consideration. Essential facts concerning this program are:

Dates: June 22-July 31, 1959

Eligible: Administrators or assistant administrators, hospitals and allied agencies

Content: Developments in medical care programs: administrative theory and practice; trends in hospital administration; each involving daily lectures, assigned readings and discussion

Faculty: Distinguished visiting lecturers plus resident faculty

Housing: Group living in "The Oaks," a Cornell fraternity house; off-campus accommodations available for families

Cost: Subsidized by the Alfred P. Sloan Foundation; charge to participant limited to $200, covering tuition, supplies, room and nearly all meals, for six-week period

Apply to: Director, H.A.D.P., Sloan Institute of Hospital Administration, Cornell University, Ithaca, New York

classified advertising

POSITIONS OPEN

DIETITIAN—Chief; Municipal TB Hospital, J.C.A.H. approved, excellent salary, permanent position; must be ADA member. Apply Superintendent, Wm. Roche Memorial Hospital, Toledo 14, Ohio.

DIETITIAN—Therapeutic; A.D.A.; immediate opening; 100-bed general hospital; 5 day week, paid vacation, sick leave, special holidays; salary commensurate with qualifications. Contact Dietitian, Grace Hospital, Richmond 20, Virginia.

DIETITIANS—Staff; 2; Capitol City's largest and newest hospital; 290-adult beds; opened 1951; centralized food service, selective menu, ADA preferred; no teaching required; $4,000 starting salary range; liberal personnel policies. Apply Director of Dietetics, Charleston Memorial Hospital, 3200 Noyes Avenue, Charleston 4, West Virginia.

DIRECTOR OF NURSING — 150-bed general hospital located 90 miles from San Francisco; good employee benefits. Apply Administrator St. Joseph's Hospital, Stockton, California.

DIRECTOR OF NURSING—For JCAH approved general hospital; after large addition is completed late this year, will have 240-beds (including a 30 bed Psychiatric Unit) and 44 bassinets; State approved Diploma School of Nursing; first inspection by NLN scheduled for early 1960; prefer applicant with M.S. degree and several years of administrative experience; starting salary around $7500 plus maintenance. Apply Administrator, W. A. Foote Memorial Hospital, Jackson, Michigan.

DIRECTOR OF NURSING—Unusual opportunity for nurse who is presently serving as supervisor, assistant director or director to conduct reorganization program and plan for new hospital; salary negotiable with attractive increases according to performance; exceptional opportunity for advancement in the field; would consider person wishing to make this position a stepping stone to similar position in larger hospital; university facilities available for advance courses; interview expenses paid. Write Bethesda Hospital, Hornell, New York.

DIRECTOR OF NURSING—Progressive 70-bed children's rehabilitation-convalescent center in New York metropolitan area; good staff, liberal personnel policies, modern apartment; salary open; Masters degree required. Write W. H. Kelley, Executive Director, Blythedale, Valhalla, New York.

ASSOCIATE DIRECTOR, NURSING SERVICE—Responsible for nursing care program in 200-bed hospital with school of nursing; B.S. degree and at least 3-5 years administrative or supervisory experience; salary open. Apply Director, School of Nursing, St. Margaret Memorial Hospital, Pittsburgh 1, Pennsylvania.

DIRECTOR OF NURSING SERVICE—For a 210-bed hospital located in the heart of America; Master's degree or equivalent in experience and education required; salary commensurate with background. Write or call Personnel Director, Sioux Valley Hospital, 1123 South Euclid, Sioux Falls, South Dakota, for full information.

EDUCATIONAL DIRECTOR — School of Nursing; 3 year diploma program; 300-bed hospital; student body of 100; B.S. in Nursing Education required with experience; salary commensurate with qualifications; hour and half from Baltimore and Washington; challenging opportunity. Apply Director of Nursing, Washington County Hospital, Hagerstown, Maryland.

INSTRUCTORS — Medical-surgical; fundamentals of nursing; and medical-surgical specialities; 225-bed hospital; N.L.N. provisionally accredited school of nursing, 100 students; B.S. and teaching experience desirable; liberal personnel policies; minimum salary for qualified person $400 per month. Apply to Director of Nursing Education, Allen Memorial Hospital, Waterloo, Iowa.

INSTRUCTORS—Clinical in medical-surgical nursing and obstetrical nursing; 3 year diploma program; 300-bed hospital; student body of 100; B.S. in Nursing Education required; salary open; hour and half from Baltimore and Washington. Apply Director of Nursing, Washington County Hospital, Hagerstown, Maryland.

LAUNDRY MANAGER—340 bed hospital; salary open, experience necessary. Contact Raymond Clark, Assistant Administrator, Robert Packer Hospital, Sayre, Pennsylvania.

ASSISTANT DIRECTOR—Medical records department; must be registered or eligible for registration; modern department; patient activity study; 514-bed hospital; good salary and personnel policies. Write Mr. J. M. Dunlop, Administrator, Bridgeport Hospital, Bridgeport, Connecticut.

(Continued on page 208)

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- Proved in a decade of hospital use.
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POSITIONS OPEN

LIBRARIAN—Registered medical records; to assume full charge of medical record department; 250-beds, suburban general hospital, Chicago area; good salary for competent person. Apply MO 275, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

LIBRARIAN—Assistant medical record; 300-bed hospital; salary commensurate with those in area. Apply Administrator, St. Joseph's Infirmary, 265 Ivy Street, N.E., Atlanta 3, Georgia.

LIBRARIAN—Medical records; for 58-bed general hospital; to be in charge of the medical records library; desirable personnel policies and starting salary; located in a resort city on the shores of Lake Michigan. Write or call collect: Ralph W. Tarr, Administrator, Grand Haven Municipal Hospital, Grand Haven, Michigan.

LIBRARIAN—Registered medical record; to take charge of a medical record library in a new modern 160-bed general hospital, JCAH accredited; pleasant working conditions; salary open. Apply Personnel Director, Miriam Hospital, 164 Summit Avenue, Providence, Rhode Island.

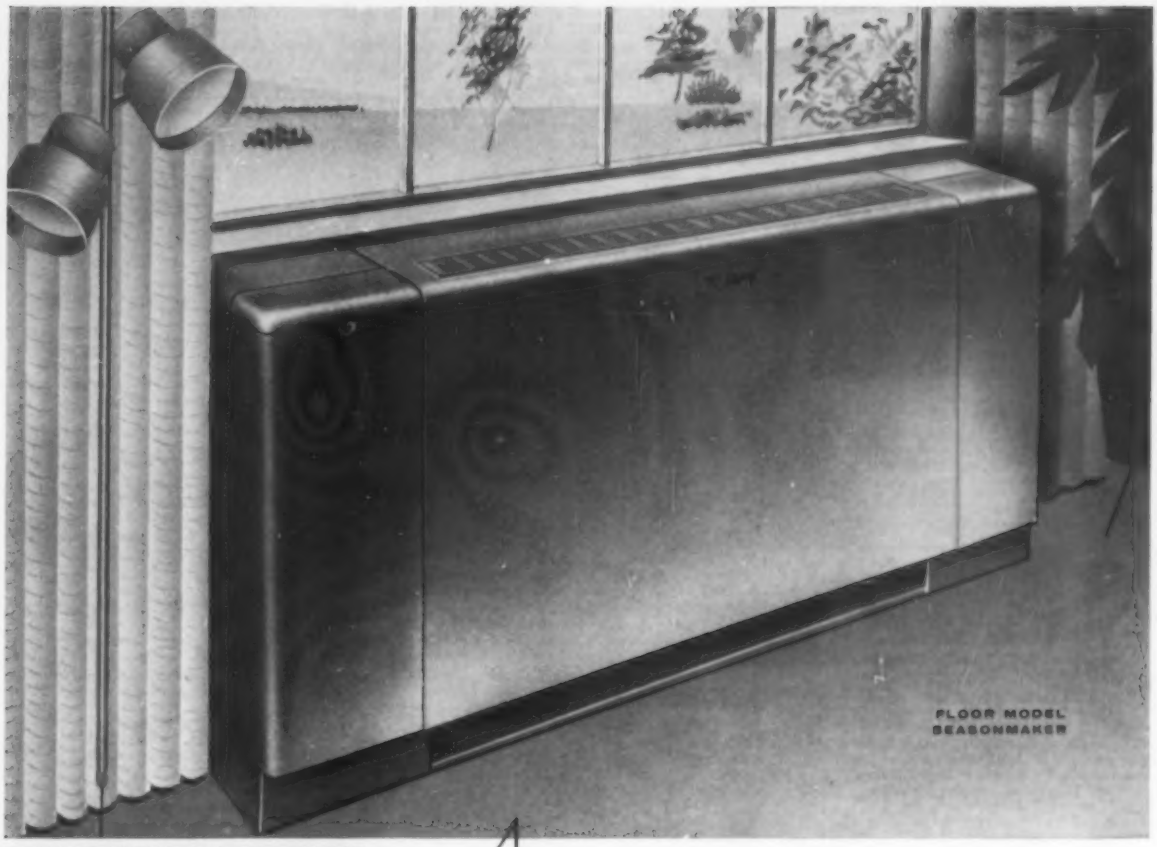
MISCELLANEOUS — Openings in large modern general hospital, Southern Metropolitan City, for; registered physical therapist, nurse anesthetists, A.D.A. dietitians, pharmacist, medical technologists and nursing education instructors; progressive personnel policies, excellent working conditions; salary based on preparation and experience. Address MO 265, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

MISCELLANEOUS — INSTRUCTORS — Diploma program in 120-bed hospital school in central New York State, 35-50 students. (a) Obstetrical Nursing; responsible for formal and clinical teaching in maternity and newborn care; B.S. degree required; salary $4500 with benefits. (b) Science; responsible for teaching biological and physical sciences; B.S. with major in sciences; Masters preferred; salary $500 with benefits. Write MO 268, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

MISCELLANEOUS—Clinical Instructor in Orthopedics and Pediatrics; Nursing Arts Instructor; and Instructor in Medical and Surgical Diseases with related subjects; Bachelor's degree in Nursing Education and some experience in teaching desirable; 180-bed hospital; diploma school, one class admitted yearly; liberal personnel policies, starting salary $5,400 per year with increases for 2 years. Apply Director of Nursing, St. Luke's Hospital, Marquette, Michigan.

MISCELLANEOUS — Supervisor-Operating Room; also openings for General Duty Registered Nurses; 85-bed hospital, fully approved by Joint Commission Western Pennsylvania; situated in famous resort area, attractive salary, liberal personnel policies. Apply to Mrs. E. Thompson, R.N., B.S., Director of Nursing, Memorial Hospital of Bedford County, Bedford, Pennsylvania.

(Continued on page 210)



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only 8½" thin

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There are four models—each in five sizes, 220, 330, 440, 520 and 640 cfm. The four smaller sizes are equipped with 1050 rpm motors, while the largest has 1500 rpm. Hand-of-coil connections are easily reversed in the field. Filters are changeable without removing decorative panels.

All McQuay Seasonmakers are ultra-quiet in operation and furnish individual room comfort at any desired temperature level. They are quick and easy to install and service, and ideal for multi-room buildings such as hotels, motels, schools, hospitals, offices and residences. Call the McQuay representative in or near your city for complete information about these new thin-line design Seasonmakers, or write McQuay, Inc., 1646 Broadway Street N. E., Minneapolis 13, Minnesota.

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POSITIONS OPEN

MISCELLANEOUS—Operating room supervisor; Operating room general duty nurse for 110-bed modern hospital; excellent personnel policies. Apply Superintendent, Charlotte County Hospital, St. Stephen, New Brunswick, Canada.

NURSES—Registered; responsible positions open; beginning salary $270 month; recently constructed 35-bed general hospital located only 3 hours from gulf coast. Apply Administrator, Jackson Hospital, Jackson, Alabama.

NURSES—Operating room; The new Palo Alto-Stanford University Medical Center; $325 to $361 per month; $20 shift premium for 3-11 & 11-7; salary increase July 1; vacation 2 to 4 weeks, retirement program, social security, hospitalization insurance, 40 hour week; rotating shift. Apply Director, Department of Operating Rooms, Palo Alto-Stanford University Medical Center, Palo Alto, California.

NURSES—Staff; The new Palo Alto-Stanford University Medical Center; $325 to $361 per month plus $20 shift premium for 3-11 & 11-7 salary increase July 1; vacation 2 to 4 weeks, retirement program, orientation program, social security, hospitalization insurance, sick benefits, 40 hour week. Apply Director, Nursing Department, Palo Alto-Stanford University Medical Center, Palo Alto, California.

NURSES—Licensed vocational; The new Palo Alto - Stanford University Medical Center; $275 to $308 per month plus $10 premium for 3-11 & 11-7; salary increase July 1; vacation 2 to 4 weeks, retirement program, orientation program, social security, hospitalization insurance, sick benefits, 40 hour week. Apply Director, Nursing Department, Palo Alto-Stanford University Medical Center, Palo Alto, California.

NURSES—Surgery; must be experienced; beautiful 83-bed hospital in Los Angeles suburb; excellent salary and working conditions; 5 day week. Apply Administrator, San Gabriel Valley Hospital, 115 E. Broadway, San Gabriel, California.

NURSE—Registered; for night duty in small 29-bed hospital in congenial town; beginning staff salary $300 per month. Apply St. Joseph Hospital, Cheyenne Wells, Colorado.

NURSES—Registered; positions open on all shifts and services including delivery and operating room; modern 60-bed hospital located in southwest Colorado; nurses must be eligible for Colorado registration; 40 hour week, paid vacations; social security, holidays, liberal sick leave and other benefits; modern quarters available for single personnel if desired. Apply Southwest Memorial Hospital, Cortez, Colorado.

NURSES—Staff; positions in all clinical areas including psychiatry and respiratory center in new 800-bed air-conditioned hospital; 40 hour week; 3 weeks vacation annually; sick leave; beginning salary $275 monthly; periodic increments; opportunity for college study through bachelor's degree program. Write Director of Nursing Service Eugene Talmadge Memorial Hospital, Medical College of Georgia, Augusta, Georgia.

NURSES—Registered; modern 98-bed hospital in Central Michigan; excellent salary and fringe benefit program; nurses residence available. Apply Clinton Memorial Hospital, St. Johns, Michigan.

NURSES—Staff; (3) fifty bed hospital, small community near St. Louis; prevailing salary, paid vacation, paid sick leave, expanding facilities. Address replies to Mr. Robert E. Harper, Jr., Administrator, Lincoln County Memorial Hospital, Troy, Missouri.

NURSES—Registered; for general duty; 76-bed hospital; salary $260 & $15 3-11, $20 11-7 per month. $5 per month increase after 6 months service; 40 hour week, 2 weeks vacation and holidays with pay after 1 year; nice college town. Apply Director of Nursing Service, Jamestown Hospital, Jamestown, North Dakota.

NURSES—Registered general duty; 100-beds; good bedside nursing required, 40 hour week; rotating duties; excellent personnel policies; you arrange for Rhode Island State Registration. Apply Nurse Director, Jane Brown Memorial Hospital, Providence 2, Rhode Island.

NURSES—Graduate; A challenging opportunity to join an inter-disciplinary team working with children having seizures who also display learning and emotional problems, in a residential facility located forty miles from Washington, D.C. starting salary between $300 and $350 depending upon qualifications and experience, with liberal personnel policies. Apply Charles Kram, Ph.D., Director, National Children's Rehabilitation Center, Leesburg, Virginia.

(Continued on page 212)

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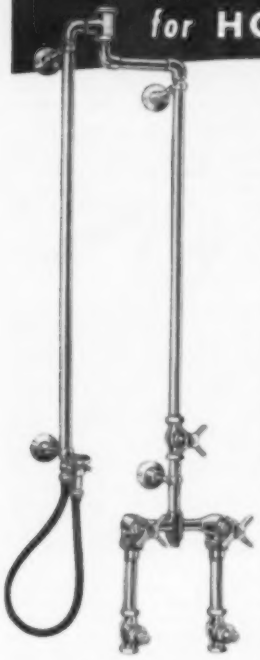

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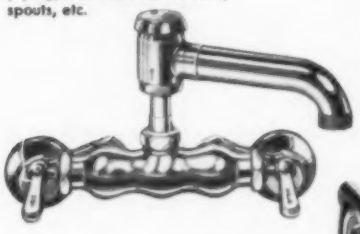
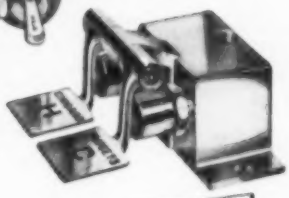
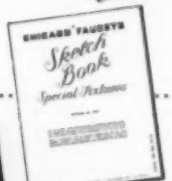
No. 904 Bed Pan Flusher, with integral vacuum breaker. Other types for concealed piping, with different nozzles, spouts, etc.



No. 886 Exposed Sink Faucet, with integral vacuum breaker. Other types with wall brace, pail hook, integral stops, etc.



No. 625 Pedal Valve, mixing type. Also wall hung pedal valves, and leg- or wrist-operated valves.



New Sketch Book has 64 pages of engineering data and dimensions on many special hospital faucets. If you buy or specify faucets write for your copy.

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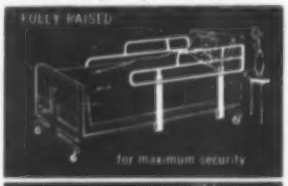
- **Provides full protection against roll-out**

A real time-saver for your busy staff! *Royal* DUAL-PURPOSE Safety Sides provide complete, nonconfining protection against bed-falls, yet permit ambulent patients the freedom and convenience of getting in or out of bed at will. *Also available*: New short-length (41½") Universal Safety-Side.

NEW SIMPLICITY

With Safety Side in intermediate position (shown above), foot end is lower than surface of mattress. Patient can easily swing feet to floor. Top bar and bed end provide hand-support for reassuring assistance. Side at center and head of bed remains sufficiently high to prevent accidental roll-outs.



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Chrome-plated sides adjust in seconds to up, intermediate, or down position. And, these new DUAL-PURPOSE sides may be used *interchangeably* on the same brackets as standard *Royal* Universal Safety Sides.

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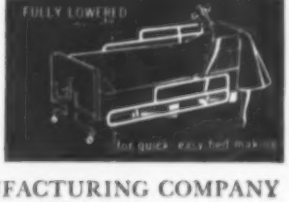

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POSITIONS OPEN

NURSES—Registered; for 50-bed general hospital; approximately 7,000 population; 48 hour week, 2 weeks paid vacation after one year; sick leave, holidays, liberal personnel policies; nurses residence available; starting salary $325 a month and full maintenance. Write Administrator, Coon Memorial Hospital, Dalhart, Texas.

NURSES—Graduate; $4188 to $7032.* For Washington State's Mental Health Program; Here is your opportunity to participate in one of the most progressive and dynamic mental health treatment programs in the country; choose your location in the state so bountifully endowed with scenic grandeur, mild climate and tremendous opportunities; no psychiatric experience necessary for graduate nurses in the entering level; 10 paid holidays, annual and sick leave, promotion by merit and an employee's retirement plan, are only a few of the attractions offered by these positions. For further information and applications, contact: Washington State Personnel Board, 212 General Administration Building, Olympia, Washington. (*Starting salaries dependent upon position and experience.)

NURSES—Registered; 170-bed general hospital; openings in operating room, delivery room and staff positions; starting base salary $300 per month; ideal climate, convenient recreational facilities year round. Apply Director of Nurses, Yakima Valley Memorial Hospital, Yakima, Washington.

NURSES — Registered; supervisors and general duty on all shifts and services; starting salary $250 for 40 hours or $290 for 48 hours weekly, guaranteed salary increases each 6 months for 2 years, differential for evenings $15, nights $10; modern, well equipped 35-bed JCAH accredited hospital; 6 paid holidays, 2 weeks vacation, 7 days sick leave or 3 weeks vacation without sick leave, social security, Blue Cross, meals on duty, laundry of uniforms; immediate employment if desired. Apply Administrator, Webster Memorial Hospital, Webster Springs, West Virginia.

NURSES—General duty; Attention: position vacancies of all types in 125-bed JCAH accredited hospital located in new residential area of Cheyenne, home of frontier days and Warren Air Force Base; many opportunities for outdoor sports and activities; excellent working conditions with liberal personnel policies; starting salaries days, $300, 40 hour week. Apply Director of Nurses, DePaul Hospital, Cheyenne, Wyoming.

PHARMACIST—Registered; male or female; for 400-bed general hospital in Hawaii; liberal personnel policies, hospitalization coverage, group life insurance, retirement, 40 hour week; state salary desired. Write Personnel Director, The Queen's Hospital, P.O. Box 861, Honolulu, Hawaii.

PHYSICAL THERAPIST—Staff; salary commensurate with training and experience; 340-bed hospital. Contact Raymond Clark, Assistant Administrator, Robert Packer Hospital, Sayre, Pennsylvania.

PHYSICAL THERAPIST—170-bed general hospital; salary open; excellent opportunity. Apply Administrator, Yakima Valley Memorial Hospital, Yakima, Washington.

SUPERVISOR-INSTRUCTOR — Operating room; 209-bed general hospital; NLN fully accredited school of nursing; 90 students; 40 hour week; special clinical preparation in operating room supervision; salary open, liberal personnel policies. Apply Director of Nursing, Middlesex Memorial Hospital, Middletown, Connecticut.

SUPERVISOR—Surgery; for 50-bed hospital with a 20-bed addition within the next year; nursing home recently completed 40 beds; town 6000, 85 miles south Chicago. Write Administrator for particulars. The Iroquois Hospital, Watseka, Illinois.

SUPERVISOR—Operating room; 79-bed voluntary hospital with building program; satisfactory supervisory experience needed; salary commensurate with qualifications; paid vacation, sick leave, 8 holidays; North Shore Long Island 60 miles east New York City. Apply Administrator, John T. Mather Memorial Hospital, Port Jefferson, New York.

SUPERVISOR — Obstetrical; for 400-bed general hospital completing large addition; fully approved by Joint Commission; intern-resident program, fully accredited school of nursing, salary open; liberal benefit program; 4 weeks vacation. Apply Personnel Director, Christ Hospital, Cincinnati 19, Ohio.

TECHNICIAN—Laboratory; Western New York area; A.S.C.P. membership desirable but not essential; in applying give qualifications and references; liberal vacation, sick leave, and fringe benefits; salary open. Apply to MO 274, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

TECHNOLOGIST — Registered medical; A.S.C.P.; male or female; required immediately for an 85-bed, rural J.C.A.H. approved general hospital, situated midway between Pittsburgh and Harrisburg; famous resort area; salary open. Apply Memorial Hospital of Bedford County, Bedford, Pennsylvania, or Telephone the Director BEdford 655.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 N. MICHIGAN AVENUE, CHICAGO

ADMINISTRATORS—(a) Medical Director 2 hospitals, combined capacity over 1000-beds; fully approved all specialties; medical school affiliation; JCAH; $16,000-$20,000; west. (b) Well qualified physician to serve as medical director, teaching hospital, foreign country; prefer Board surgeon or obstetrician-gynecologist; 3 year contract. (c) Medical Superintendent, tuberculosis hospital; university town, south; $10,000, complete family maintenance. (d) To direct general hospital, Africa; considerable experience required. (e) Young director, take charge, new hospital under construction; California. (f) Assistant administrator; 200-bed hospital; residential town near Philadelphia; (g) Director; 100-bed hospital; expansion program; small town; Pacific Northwest; $650-$800. MH6-1

ADMINISTRATIVE PERSONNEL — (a) Accountant qualified to serve as financial consultant to a group of 12 hospitals, one in South Carolina, others in midwest; some travel; excellent opportunity to become controller for the entire group. (b) Controller, foreign university; capable taking over financial control; familiar with budget control; cost accounting; must have mature judgment. (c) Personnel Director; 450-bed hospital; university city; west. (d) Food Manager, industrial management concern. MH6-2

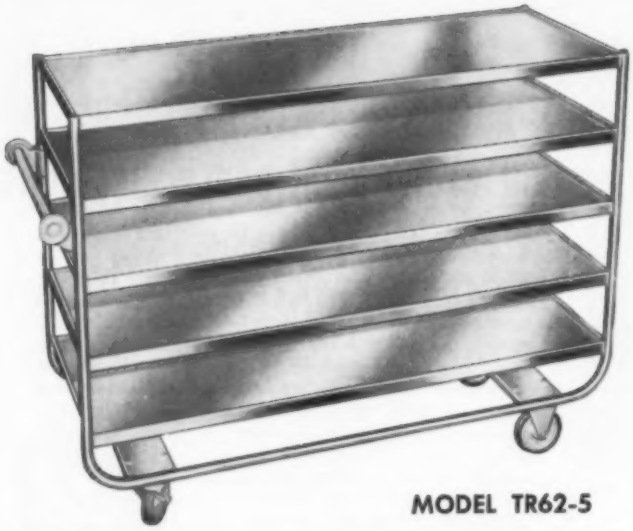
(Continued on page 214)

Swartzbaugh Manufacturing Company proudly hails 75 years of making the finest hospital equipment possible with the introduction of IDEAL's new lines of Tray Trucks and Dish Trucks. These trucks have the same high quality of design, materials and workmanship which have characterized Swartzbaugh equipment for three quarters of a century. They are worthy additions to the IDEAL line of the best in hospital equipment.

MODEL TR36-3

New

COMMEMORATING Swartzbaugh's 75th YEAR



MODEL TR62-5

IDEAL TRAY TRUCKS AND DISH TRUCKS

- All stainless steel, tubular construction, with integral v-nose raised edge shelves.
- Sturdy u-brace frame, built for long efficient service.
- Tubular push handle bolted firmly to uprights.
- Available with or without donut bumpers.
- Ball-bearing, rubber tired casters specially engineered for ease of mobility and long life. Mounted in channel bolsters—easy to install, easy to remove.
- Dish Truck has removable center shelf. It may be removed or installed in the field.

	Model	Overall Length	Overall Width	Overall Height	Shelf Size	No. of Shelves	Shelf Clearance	Net Weight
Dish Truck	TR36-2	40⅞"	25"	37½"	23" x 36"	2	21½"	90 lb.
Dish Truck*	TR36-3	40⅞"	25"	37½"	23" x 36"	3	10"	100 lb.
Tray Truck	TR52-4	56⅛"	25"	49"	23" x 51½"	4	10"	136 lb.
Tray Truck	TR52-5	56⅛"	25"	49"	23" x 51½"	5	7⅛"	158 lb.
Tray Truck	TR62-4	66⅛"	25"	49"	23" x 62"	4	10"	153 lb.
Tray Truck	TR62-5	66⅛"	25"	49"	23" x 62"	5	7⅛"	178 lb.

*Removable shelf

Note: For models with bumpers, there will be a change in width and length

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MURFREESBORO, TENN.

Ideal® HOSPITAL EQUIPMENT
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classified advertising

POSITIONS OPEN

MEDICAL BUREAU—Continued

ANESTHETISTS—(a) Only one on staff of small Alaska hospital; prosperous, progressive city; maintenance available; $550 up. (b) Pacific Northwest, 50-bed hospital; $7200. (c) Join staff of 8; 500-bed hospital; ideal Florida summer-winter resort; $6300-$6900. (d) Need third anesthetist; 125-bed hospital; busy surgery; leading midwest city; $8500 start. MH6-3.

DIETITIANS—(a) Chief, leading New York City hospital; strong administrator required; top salary. (b) Industrial dietitian; renowned food concern; east; $5000-$7000. MH6-4

DIRECTORS OF NURSES—(a) Direct service and school, 350-bed hospital near New York City; $7000-$10,000. (b) Psychiatric hospital, 2000-beds; direct nurses education; consult in new expansion program; midwest; $6000-$7000. (c) Direct all graduate staff, 130-bed hospital; Michigan lake resort, $6,800. (d) Assistant, nursing service, new 400-bed hospital; excellent opportunity, young progressive nurse; California; top salary. MH6-5

MEDICAL BUREAU—Continued

EXECUTIVE HOUSEKEEPER—(a) New 400-bed hospital; ideal southwest location; top salary; (b) Manage department, 450-bed hospital; university town near New York City; $5000-$6000. MH6-5

INSTRUCTORS—(a) Director; direct Clinical Nursing; university basic program; academic appointment; $6500; south. (b) Medical-surgical instructor; California; collegiate nursing program; $450 (b) Fundamentals of nursing, university appointments; east and west coast; $5000-$6000. MH6-7

MEDICAL RECORD LIBRARIANS—(a) Chief, foremost southwestern medical clinic; renowned research center; $6000. (b) Medical record librarian, small Arizona hospital; need not be registered; $400 month. MH6-8

SUPERVISORS—(a) Ready to assume responsibility for nursing service, 85-bed hospital, New York; $6000-$7000. (b) OB, no teaching; busy 80-bed maternity department; $5000-$6000, midwest. (c) OR, administrative skill required for 9-room suite; leading Eastern hospital; $5500-$6000 up. (d) Take charge small nursing home in owners absence; $4200 up, maintenance; resort town near Chicago. MH6-9

Our 63rd Year

WOODWARD MEDICAL PERSONNEL BUREAU
FORMERLY A.J.NOES
185 N. Wabash Chicago, Ill.

Telephone: RAndolph 6-5682

ADMINISTRATORS — (a) Medical Director; medium-sized tuberculosis hospital; to $20,000 1st year. (b) Chief of Professional Services; new chronic diseases hospital; New England. (c) Medical Director; prefer ACHA; 500-bed, fully approved, general hospital, expanding 300-beds; to $20,000; west coast. (d) Small, general, JCAH hospital; $10,000; suburb, large midwest city. (e) 130-bed, voluntary, general hospital; requires experienced hospital director; vicinity Philadelphia. (f) 250-bed hospital in planning stage; employing now; $20,000; California. (g) 500-bed, fully-approved, general hospital; requires ACHA; $18,000; south. (h) ACHA or equivalent; fairly large, general hospital now building; employ now; $15-18,000; mideast. (i) New 100-bed, general hospital, nearing completion; $12-15,000; with percentage later; resort city, southwest. (j) 160-bed, voluntary, general, medical-school-affiliated hospital, adding 40-beds; about $12,000; northeast. (k) Assistant; 180-bed, voluntary, general, JCAH hospital, medical-school affiliated hospital; new post; good salary with increases; east. (l) Assistant; 250-bed, general, fully-approved, JCAH hospital; $7-8,000; mideast.

WOODWARD—Continued

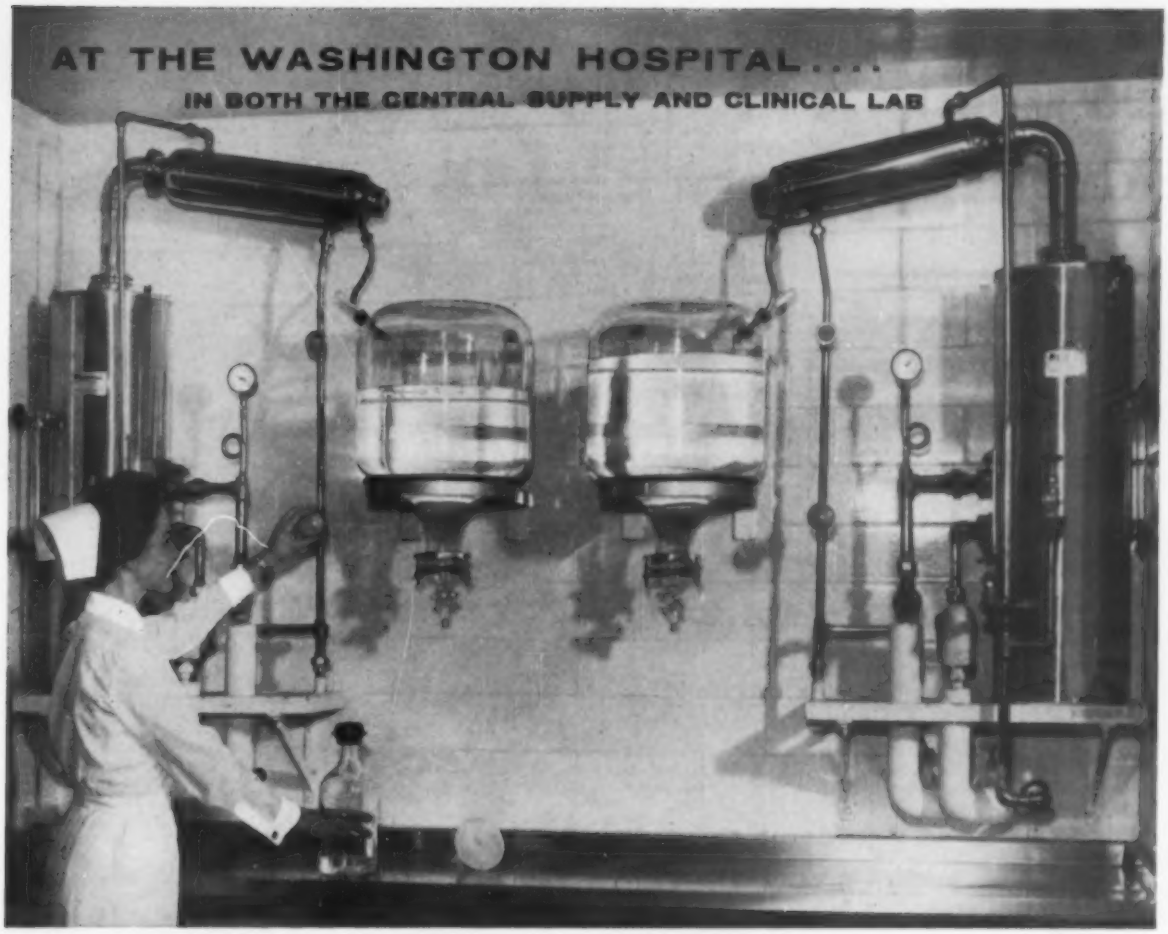
ADMINISTRATIVE POSTS — (m) Assistant business manager; good accounting background; 450-bed, fully-approved, voluntary, general hospital; $4-5,000; east. (n) Comptroller; 200-bed, general hospital; $10,000; California. (o) Personnel director; 440 persons, hospital center; $5-7,500; large city, southwest.

A & G MEDICAL PERSONNEL AGENCY
834 Second Street
Lancaster, Pennsylvania

ADMINISTRATION — Administrative assistant; capable handling public relations and personnel affairs; M.A. in Hospital Administration preferred; salary high; Pennsylvania.

BIOCHEMIST — M.A. in Biochemistry necessary; 215-beds; work interesting and rewarding; salary depends on individual qualifications and experience.

(Continued on page 216)



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Like thousands of hospitals the world over, the Washington Hospital in Washington, Pennsylvania, relies on Barnstead Stills for the purest, pyrogen-free, distilled water.

In its CENTRAL SUPPLY where flasks, bottles, needles, tubing, trays, etc., are washed and rinsed in distilled water, the Washington Hospital finds that Barnstead distilled water gives optimum results. Here, in the Central Supply, two Barnstead Stills are in continuous operation.

In its LABORATORY where complete freedom from organic and inorganic solids, bacteria and dissolved gases is a must . . . another Barnstead Still produces distilled water of constant, unvarying purity.

Whatever your requirement . . . there's a Barnstead Still to fill your needs precisely . . . over 200 models and sizes backed by over 80 years of specialized experience in Water Still design. Write for Hospital Catalog "H"

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STILL & STERILIZER CO.
31 Lanesville Terrace, Boston 31, Mass.

The Hospital Standard In Water Still Design Since 1878

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POSITIONS OPEN

A & G MEDICAL—*Continued*

BACTERIOLOGIST—B.S. level charge bacteriology section laboratory; large hospital, salary open.

PHARMACIST—(a) Immediate opening, large hospital, salary open; Ohio. (b) Hospital and large group practice with expansion program; future very good, salary to $6,500; Florida. (c) Assistant, 300-beds, air-conditioned, salary open; Maryland.

PHYSICIANS — (a) Anesthetist, Board Certified, become chief of service, 183-beds, salary or other basis; Virginia. (b) Pathologist; 165-beds with expansion; immediate opening, salary open; Pennsylvania. (c) Pathologist; Chicago area, 100-beds and expanding, salary open. (d) Psychiatrist; 1700-beds mental; excellent salary; midwest location; hospital will pay travel expenses for interview. (e) House Physicians—(f) 2 vacancies; salary according qualifications and living accommodations for one; Pennsylvania.

A & G MEDICAL—*Continued*

(g) Salary open and depends on ability and experience; New York. (h) Salary to $10,000 and quarters for unmarried; Pennsylvania license or eligible by reciprocity.

NURSES-DIRECTOR OF NURSES-DIRECTOR OF SCHOOL OF NURSING AND INSTRUCTORS—(a) Director of Nurses; 135-beds and expanding; college town, salary open; Pennsylvania. (b) Director of Nurses; hospital located near resort area, salary open; New Hampshire. (c) Director of Nursing Service; 168-beds, salary range to $7,500; Pennsylvania. (d) Educational director; 190-beds and expanding, salary open; Massachusetts. (d) Educational director; 300-beds, salary depends on qualifications; Maryland. (f) M/S Clinical instructor, and nursing arts instructor; 190-beds, salary open; Massachusetts. (g) M/S Clinical instructor and nursing arts instructor; 115-beds, salary open; midwest. (h) Clinical instructor; salary $4,200, 40 hour; east. (i) M/S Clinical instructor; instructor fundamentals of nursing and assistant director school of nursing; salary to $500 depending on experience; southwest. (j) M/S and OB clinical instructors; 300-beds, excellent salary; Maryland. (k) Educational director and nursing arts instructor; 300-beds, salaries open; Virginia.

NURSES-SUPERVISORS — (a) Operating room; new medical center, salary open; east. (b) Operating room; medium size hospital, salary depending on qualifications; midwest. (c) Obstetrical; 250-beds and expanding; person selected will help plan area; salary open; Ohio. (d) Obstetrical; 115-beds, liberal policies, salary open; midwest. (e) Operating room; 3-11 P.M. shift, 140-beds; salary open; midwest.

NURSES-ANESTHETISTS — (a) 669-beds and expanding, salary $559 to $648; midwest. (b) Small hospital, fully accredited, salary open; Arizona.

A & G MEDICAL—*Continued*

SCHOOL NURSE—$425 month, plus car allowance, inexperienced, additional amount for experience; west.

PHYSICAL THERAPISTS—(a) Female; 350-beds; increased facilities near future, salary open; Ohio. (b) Male or female, all new facilities, 81-beds, salary open; west.

FOOD MANAGER—Male; 360-beds, buying experience preferred, salary high; south.

DIETITIANS—(a) ADA preferred, 115-beds, plan and direct department, salary open discussion; midwest. (b) 72-beds, salary $4,000; New York. (c) 90-beds, excellent working conditions, salary open; Michigan. (d) Therapeutic and administrative; 400-beds college and resort city, 40 hours, salary to $450 depending on experience; midwest.

MEDICAL RECORD LIBRARIANS—(a) Chief, 10 assistants, salary range $5,400 to $5,800; east. (b) Chief, 220-beds, salary open; Ohio. (c) Chief, 100-beds and expanding; Chicago area, salary open. (d) 50-bed general hospital, able to revamp department; registration not required, salary open; New York.

MEDICAL TECHNOLOGISTS AND TECHNICIANS—(a) ASCP; 151-beds, 2 openings, daytime and afternoon shift, salary range $400 and higher for afternoon shift; Michigan. (b) Registered; 120-beds, capable becoming chief, salary open; New Jersey. (c) Experience in clinical bacteriology also; department air-conditioned, large hospital, salary open; Ohio. (d) 200-beds, registration required, 2 openings, salary range $400; Kentucky. (e) ASCP and capable X-ray, $450 plus perquisites; Florida. (f) registered and capable X-ray, salary starting $350 plus payment each call; Arizona. (g) Immediate opening, hospital to affiliate with School of

(Continued on page 218)

classified advertising

POSITIONS OPEN

A & G Medical—Continued

Medicine, salary open; West Virginia. (h) 2 openings; experience in chemistry, salary open; Pennsylvania. (i) Several openings, 600-beds, ASCP preferred, 40 hour, salary open; Ohio. (j) 100-beds, 2 openings, salary open; Virginia. (k) Chief, preferably one who knows X-ray, 90-beds, fully air-conditioned, excellent personnel policies, salary open; Florida. (l) 90-beds, 2 openings, 44 hours, $375 month starting; Mich. (m) Small hospital; registered and capable X-ray, salary open and additional for call time; Arizona. (n) 85-beds, male preferred, salary open; New York. (o) Staff technician and one to head department; male or female; salaries open; southwest.
Inquiries confidential. Write for details. No registration fee.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland 15, Ohio

PERSONNEL DIRECTOR—(a) 350-bed eastern hospital. (b) Large organization, south central states; hospital experience desired.

ADMINISTRATOR—(a) 120-bed hospital, eastern community; open July; accounting background. (b) 40-bed hospital; West Virginia. (c) 115-bed Ohio hospital. (d) Convalescent hospital; New England.

PURCHASING AGENT — (a) 600-bed hospital; Ohio. (b) 175-bed Sisters' hospital; west.

BUSINESS MANAGER—(a) 250-bed hospital; Texas. $7200. (b) 275-bed hospital; Pennsylvania. (c) Private hospital; midwest.

DIRECTOR, NURSING SERVICE—(a) 200-bed Pennsylvania hospital. (b) 350-bed Ohio hospital. (c) 100-bed Illinois hospital. (d) 75-bed hospitals; Maryland, Virginia, Michigan, Iowa.

DIRECTORS, NURSING EDUCATION—To $7200.

PHARMACISTS—(a) $6500. (b) Bacteriologist, $5,000. (c) X-ray technicians, $5,500. (d) Physiotherapist; to organize department; 150-bed hospital.

EXECUTIVE HOUSEKEEPER—(a) 500-bed hospital; east; $6,000. (b) New 300-bed hospital; midwest. (c) 350-bed hospital; Pennsylvania. (d) 200-bed hospital; southwest.

MEDICAL EMPLOYMENT SERVICE
59 East Madison Chicago 2, Ill.
ANdover 3-5663-64
Alfred E. Riley, R.N., MSHA Director

ADMINISTRATORS — (a) New 60-bed general hospital; eastern area, salary open. (b) 100-bed, new Florida hospital, fine opportunity; salary open.

(Continued on page 220)

Completely Modern!

The New MULTI-CLEAN FLOOR MACHINE

14", 16", and 22" MULTI-CLEAN Floor and Scrubbing Machines are similar to the 19" models shown here. MULTI-CLEAN Lite-12, Lite-14, 31", and Explosion-proof Machines are also available.

- Heavy, 3-conductor cable is detachable.
- Cable plugs into recessed receptacle in handle. No exposed "pigtail."
- Handles have comfort grips; tapered back at natural, non-tiring angle for operator.
- Dual, independent acting switch levers give finger-tip control with *either* hand.
- 4-blade knife-type switch contains *more copper* than any other floor machine switch we know of . . . therefore switch failure is a rare occurrence.
- Handle is adjustable to any position from upright to horizontal. Regardless of handle position, machine stays in near perfect balance.
- Large stationary wheels make it easy to move from place to place, up and down stairs, over sills, etc. Axle supported at 4 points for maximum strength.
- Bumpers completely circle base and top.
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- *All ball bearinged* gear unit is designed and manufactured exclusively by MULTI-CLEAN for this purpose. 12 gear teeth in mesh at all times. Quiet, factory-sealed and lubricated.

MULTI-CLEAN® *Method*

Here's another MULTI-CLEAN engineering triumph . . . a complete new line of the world's *most modern* Floor Machines. Sleek . . . elegant . . . rugged . . . *and champions in performance.*

Beneath their graceful styling, these exciting and versatile machines offer mechanical features not available in any other models on the market today.

Before you buy a machine for polishing, scrubbing, dry-cleaning, waxing, buffing, sanding, grinding, or trowelling, it will pay you to investigate the savings and other advantages you will enjoy when you own a MULTI-CLEAN.

All Multi-Clean 12, 14, 16, 19, and 22 inch Floor Machines can be converted into efficient Scrubbing Machines by addition of poly-plastic solution tank, controls, and channel feed brush.

For more information on MULTI-CLEAN Floor and Scrubbing Machines, call your local MULTI-CLEAN Distributor or write to MULTI-CLEAN Products, Inc., Dept. MH-67-69, St. Paul 16, Minnesota.

classified advertising

POSITIONS OPEN

MEDICAL EMPLOYMENT—*Continued*

PERSONNEL DIRECTOR — Ideal Texas location, 225-beds, salary based on education, plus experience.

BUSINESS MANAGER—Needed at once; will combine with credit and collections, salary open.

PHYSICAL THERAPISTS—(a) Florida resort area. (b) General hospital in beautiful Wisconsin area. (c) 125-bed general hospital southern Illinois; salary open.

FOOD SERVICE MANAGER — 325-bed hospital; mid-east location.

DIRECTOR OF NURSES—New Hospital, excellent opportunity, interviewing now; Illinois location; salary open.

MEDICAL RECORDS LIBRARIANS—200-bed hospital in beautiful residential area; several openings for qualified registered candidates.

LABORATORY TECHNICIANS — ASCP for Colorado vicinity and other areas; also positions available for Chief Laboratory technicians and registered x-ray technicians.

DIETITIANS—Several openings; all areas.

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

ADMINISTRATORS—(a) South; 50-bed hospital-opened its doors in February of 1959. (MH-3051) (b) Southeast; 120-bed hospital; present administrator is retiring. (MH-3031) (c) Alaska; small hospital; prefer R.N. or someone with laboratory or X-ray experience. (MH-2978) (d) California; assistant administrator; 220-bed teaching hospital; will also serve as business manager. (MH-2848) (e) South; assistant administrator; 275-bed hospital in large city; good academic background plus some practical experience. (MH-2764).

EXECUTIVE PERSONNEL—(a) Personnel director; southwest; 430-bed hospital — 900 employes. (MH-3016) (b) Personnel director; east — near Boston; duties will be to assist director of house services; 350-bed hospital. (MH-2798) (d) Purchasing agent; east; 500-bed hospital; require hospital experience. (MH-2828) (e) Personnel-public relations director; this is a new position with a 500-bed hospital and offers a good opportunity. (MH-2969). (f) Business manager; southwest; good accountant; 250-bed hospital 600 employes. (MH-3101).

PLACEMENT BUREAUS

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PLACEMENT BUREAUS

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Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven methods shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidates for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee
Agency

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Suite 603 — ANdover 3-5293
Dorothea Bowlby, Director

A Specialized Employment Service for Medical and Hospital Personnel, (Men and Women.) For Administrators, Personnel Directors, Business Managers, Dietitians, Physicians, Director of Nurses, Therapists, Pharmacists, Medical Record Librarians, Anesthetists, Public Relations Directors, Housekeepers, Bacteriologists, Biochemists, Medical Technologists, X-Ray Technicians, Food Service Managers. All inquiries from applicants are kept strictly confidential.

FOR SALE

NURSING AND MEDICAL BOOKS
We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Street, Chicago 12, Illinois.

The "how-to-do-it" series of articles on housekeeping technics, reprinted from The Modern Hospital, is now available in book form. Valuable teaching aid for training housekeeping employes. Write: Emily C. Deming, Butterworth Hospital, Grand Rapids, Mich.

American 120-inch, 2-lane sheet folder. Ideal for hospital work. Good condition.
MAGIC CITY SHEET METAL, Ora Avenue Barberton, Ohio.

(Continued on page 222)

New ACOUSTIROC ceiling holds hospital noises down to a murmur

EVERYBODY appreciates a quiet lobby. Your patients will be more comfortable and your staff happier when the clatter of heels and voices has dropped to a murmur. Gold Bond Acoustiroc does just that for you by absorbing up to 85% of all noise that strikes it.

It's fireproof—the mineral fibres *can't* burn. Stable in high humidity, Acoustiroc is good for use at entrance ways. The clean white surface diffuses up to 91% of light, is easily vacuum-cleaned or repainted.

Best yet, Acoustiroc costs less than most incombustible tiles! Include it in your next remodeling plans. A Gold Bond® acoustical contractor, listed in the Yellow Pages, will give you the full details. For technical information, write Dept. MH-69, National Gypsum Company, Buffalo 13, New York.

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BUILDING PRODUCTS
NATIONAL GYPSUM COMPANY

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SCHOOLS—SPECIAL INSTRUCTION

SCHOOL OF ANESTHESIA—Approved by the A.A.N.A. Open to registered nurses of accredited schools of nursing. Applications being accepted. For complete information write to Susan C. Prince, Director of School of Anesthesia, The Memorial Hospital, Wilmington, Delaware.

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

SCHOOLS—SPECIAL INSTRUCTION

UNIVERSITY OF MICHIGAN School for Nurse Anesthetists offers a 16 month course for nurses interested in anesthesia. Accredited by the American Association of Nurse Anesthetists. The training includes all techniques in inhalation, intravenous, and rectal anesthesia. Unlimited opportunities for endotracheal intubation and open chest anesthesia. Stipend provided. For information write School for Nurse Anesthetists, University Hospital, Ann Arbor, Michigan.

BARNES HOSPITAL: Offers an 18 month post-graduate course in Anesthesia to registered graduate nurses. Theoretical requirements of the American Association of Nurse Anesthetists met. Miss Helen Vos, R.N., B.S. Educational Director. Clinical training includes all techniques and procedures. Stipend provided. For information, write Mrs. Dean Hayden, Director, School of Anesthesia, Barnes Hospital, St. Louis 10, Missouri.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00 approved by the American Medical Association. For further information, write the director of Laboratories, Barnes Hospital 600 S. Kingshighway, St. Louis, Missouri.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

JOHNS-MANVILLE TERRAFLEX® TILE
—the best value for hospital flooring dollars

Made of vinyl resins reinforced with indestructible asbestos fibers, Johns-Manville Terraflex tile meets all the needs and rigid requirements for sanitary, durable and minimum-care flooring in modern hospitals.

Actual on-the-job figures show that J-M Terraflex tile cuts floor maintenance as much as 50%, when compared with the next-best resilient type flooring.

Terraflex will outwear many other types of resilient floorings of the same thickness two-to-one.

Decorative...

Wide range of beautiful colors and styles can create unlimited interesting and cheerful effects for various hospital flooring areas.

Quiet...

J-M Terraflex tile muffles footsteps on hospital floors. It is resilient and comfortable to walk on.

Stain Resistant...

The smooth, non-porous surface of Terraflex tile resists commonly used disinfectants, acids, alcohol, fats, grease and moisture.

For complete information and color charts, write to: Johns-Manville, Box 158, New York 16, N. Y.

JOHNS-MANVILLE

JOHNS MANVILLE JM PRODUCTS

ONLY CARRIER OFFERS ICEMAKERS WITH CERTIFIED CAPACITY

There are 16 Carrier ice machines to give you exactly the kind of ice you need, cubes, crushed, flakes or chips. You can be sure you'll get the amount of ice you expect, too, because every Carrier ice machine comes with capacity certified in writing.

There are no "up to" qualifications. There are no "average" production figures. Capacity is determined according to air and water temperatures where you are.

You can save as much as 30% on ice with a Carrier Icemaker. Your Carrier dealer will give you the exact figures—and a lot of other trustworthy facts. Call him. He's listed in the Yellow Pages under Ice Making Equipment. Or, write to Carrier Corporation, Syracuse 1, New York.

Carrier AIR CONDITIONING • REFRIGERATION

QUIET *as a whisper...*

"HOSPITAL DESIGNED" Maysteel CASEWORK

Doors . . .
Sound-deadened double-pan design, soft rubber roll catches, and rubber cushion stops for quiet action.

Door Slides . . .
Noiseless formica glides, no metal-to-metal contact, no roller rattle.

Drawers . . .
Move on noiseless maple glides, close on soft rubber cushion buttons. Stop where wanted. Quiet, smooth-operating even under heavy load.

• Choosing casework by "decibel count" is one good way to determine if the quality you seek in casework is built into the casework you buy. In Maysteel Casework, lack of noise — the absence of annoying squeaking, clattering, banging — is a matter of careful engineering, and is a genuine proof of Maysteel built-in quality. For quiet, easy-operating casework, *choose* Maysteel. Return the coupon for complete details.

MAYSTEEL PRODUCTS, INC.
738 N. Plankinton Ave., Milwaukee 3, Wisconsin
☐ Send New Maysteel Catalog and Planning Guide
☐ Give us name of nearest Maysteel representative
Name .....
Address .....
City ..... State .....
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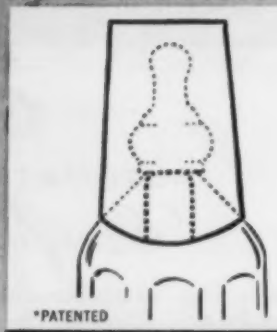

*PATENTED

for quick, dependable protection to nursing bottles . . . use the original NipGard* covers. Exclusive patented tab construction fastens cover securely to bottle • For High Pressure (autoclaving) . . . for Low Pressure (flowing steam).

NipGard TRADEMARK

DISPOSABLE NIPPLE COVERS . . .
provide space for identification and formula data . . . instantly applied to nipple; save nurses time...cover **both** nipple and bottleneck. Do not jar off. No breakage.
Use No. 2 NipGard for narrow neck bottle . . . use No. H-50 NipGard for wide mouth (Hygeia type) bottle. Be sure to specify type desired.

THE QUICAP COMPANY, Inc.
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Your hospital supply dealer has NipGards. Professional samples on request.

Now! You can simplify bathing of patients with... Sit-a-Bath®

Light-Weight!
Easily Cleaned!
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Reasonably Priced!
Strong, indestructible fiberglass!

The new Sit-A-Bath provides the only completely satisfactory method of bathing the patient who cannot use a conventional tub or shower. Greatly simplifies bathing of patients, saves precious time.

Write Today for complete information on product and price.

Another quality product of

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INCORPORATED
710 North Brookfield
South Bend 28, Indiana

On entry duty... night and day

STANLEY *MAGIC-DOOR* CONTROLS

Nowhere is increased efficiency more necessary than at hospital passageways where efficiency can be a matter of life or death. Stanley Magic-Door controls make that vital extra efficiency possible.

At delivery room entrances, nurses can carry new-born infants with complete safety through doors that open and close automatically. At operating room and emergency entrances, attendants never need to leave their patients to open and close doors manually.

The need for automatic door operation is *real.*

The name to rely on is Stanley Magic-Door . . . leader in the field for over a quarter-century. Write for free literature and the name of the Magic-Door distributor in your area to Magic-Door Sales, The Stanley Works, Dept. F, 50 Lake St., New Britain, Conn.

Sales, installation and service distributors in principal cities in the United States and Canada.

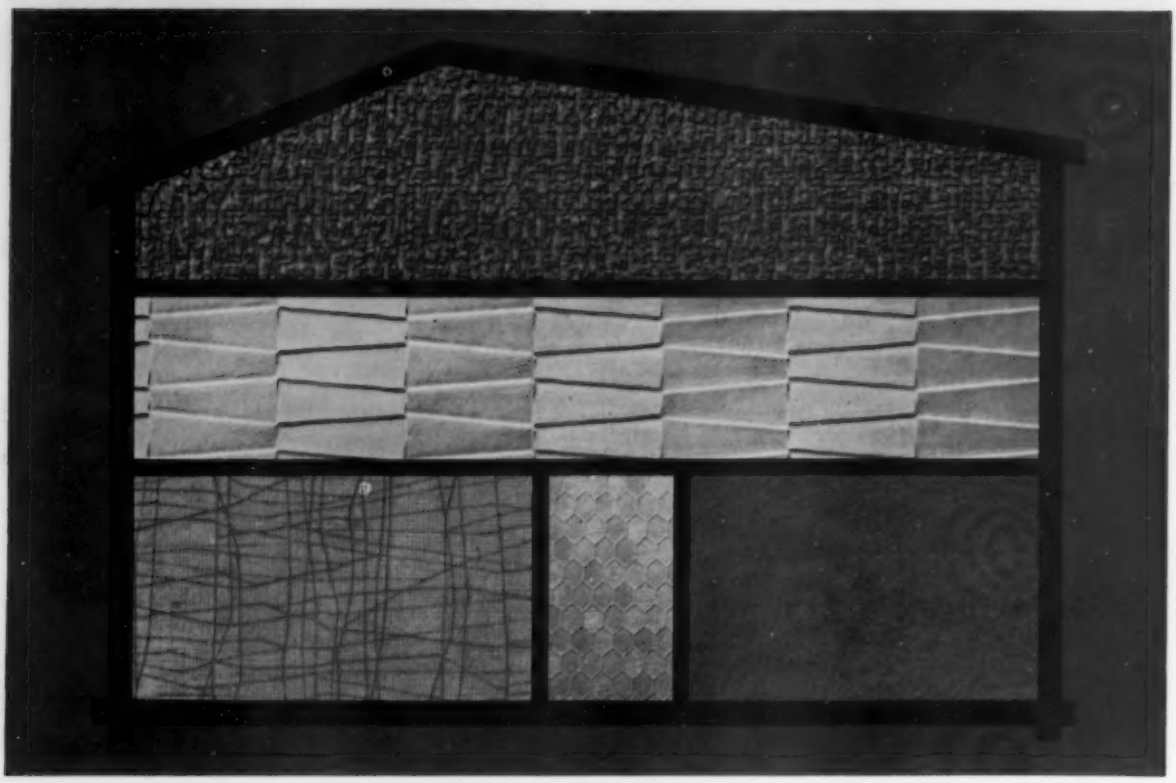
Deserving a place in your plans for progress

AMERICA BUILDS BETTER AND LIVES BETTER WITH STANLEY

STANLEY®

This famous trademark distinguishes over 20,000 quality products of The Stanley Works—hand and electric tools • builders and industrial hardware • drapery hardware • door controls • aluminum windows • stampings • springs • coatings • strip steel • steel strapping—made in 24 plants in the United States, Canada, England and Germany.

Newest Vinyl Wall Decoration



GUARD

first completely coordinated vinyl wall covering system

Get the right weight...right color and pattern...the right price for every wall area

From heavy duty service areas to rooms that greet the public you can now decorate every wall dramatically, correctly, economically from a single source — Guard.

The Guard system consists of more than 200 patterns and colors in five qualities to meet your varying requirements of style, durability, maintenance and cost. Qualities are fully color-coordinated for direct matching or correlation.

Redecorate in a Day

Guard designs are created solely for wall covering. They are excitingly new in styling, with a wide range of multi-color effects. Laboratory tests prove Guard will stand up under a lifetime of washings. In flame resistance it meets requirements of the strictest building codes.

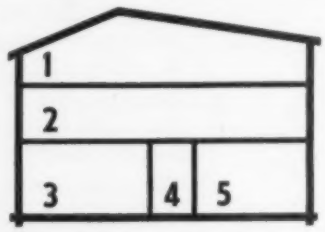
Guard patterns are pre-trimmed. They can be applied quickly and cleanly. There is no mess, no after-odor, no loss of revenue from rooms shut off for redecoration. A room vacated in the morning can be decorated with Guard and ready for occupancy the same evening.

"Eliminates Upkeep"

Many of America's fine institutions have installed Guard. The Director of Mt. Sinai Hospital, Chicago writes, "Guard is now being used throughout our hospital with excellent results. Areas formerly badly damaged by public and vehicular traffic now maintain a clean, fresh appearance with minimum attention. Guard eliminates expensive upkeep."

Free File Folder

Guard folder contains swatches of Guard qualities, patterns and colors, test specifications, installation instructions, list of users. You should have a copy in your files. Ask your authorized Guard distributor. Or write us, Attention, Commercial Building Division.



1. **QUEEN'S GUARD** heavy duty, economy vinyl
2. **KING'S GUARD** heavy duty, high style vinyl
3. **PRINCESS GUARD** high style, economy
4. **PRINCE GUARD** high style, scrubbable vinyl
5. **ROYAL GUARD** heavy duty vinyl

GUARD®

Architectural Wall Covering

SYSTEM

COLUMBUS COATED FABRICS CORPORATION, COLUMBUS 16, OHIO

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form on page 253. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Expend-Tex Surgeons' Gloves Are Fully Disposable

An entirely new disposable latex surgeons' glove is introduced under the name

Expend-Tex. Designed to surpass existing rigid standards in comfort and sensitivity for the surgeon, Expend-Tex gloves are economical enough to be disposable. Thinner at finger tips, Expend-Tex gloves are heavier at the wrists for extreme stretching when gloving. Snug-fit, flat wrists prevent roll-down. Available in white or brown latex, the gloves are packaged ready for sterilization. **Massillon Rubber Co., Massillon, Ohio.**

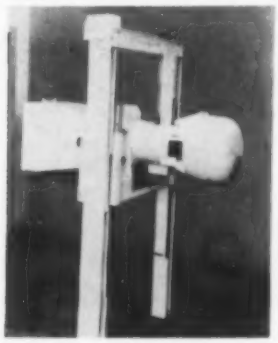
For more details circle #706 on mailing card.

Anesthetist Chair Has Conductive Casters and Seat

A conductive cover over thick rubber padding provides a comfortable seat on the new No. 404 Anesthetist's Chair. Conductive casters on the chrome-finished legs contribute to its safety in use and the stool is instantly adjustable from 21 to 31 inches in height. **F. & F. Koenigkramer Co., 96 Caldwell Drive, Cincinnati 16, Ohio.**

For more details circle #707 on mailing card.

PF Stand and Odelco Camera for Survey and Admission Work



A combination unit for survey and hospital admission work is available in the new Westinghouse fluoroscopic PF stand and 70mm Odelco camera. The 30 inches of vertical camera motion permits comfortable examination of adults or children and patient positioning is facilitated with the counter-balanced manual height adjustment with single-control locking mechanism. The 28-inch space between columns and legs of the stand permits stretcher and wheel chair examination. **Westinghouse Electric Corp., X-Ray Dept., Box 416, Baltimore 3, Md.**

For more details circle #708 on mailing card.

Weckink Sterilizing Bags Hold Various Items

Developed for packaging syringes, needles, catheters, instruments, surgeons' gloves and similar items for autoclaving, the new Weckink Sterilizing Bags have printing that turns green when autoclaved. Formed of special wet strength paper and water-resistant glue, the bags come in six convenient sizes. **Edward Weck & Co., 135 Johnson St., Brooklyn 1, N.Y.**

For more details circle #709 on mailing card.

Zylon Carafe System Eliminates Cross Infection

Daily replacement of very low-cost disposable liners in the new Zylon molded water carafe helps to eliminate cross infection hazards in patient water service. The system includes a tumbler and a separate cover in addition to the lined, wide-mouth carafe. All parts are molded of Pro-fax® a new polypropylene plastic that is highly resistant to heat and therefore can be autoclaved between patients for complete sanitation. **Zylon Products Co., Inc., 42 Church St., Pawtucket, R.I.**

For more details circle #710 on mailing card.

Rapid Slide Test for Gamma Globulin Levels

Test reactions are clearly visible in two minutes with the new GG-Test for estimating gamma globulin levels. The new slide test is based on a latex fixation reaction and supplies prompt results from one drop of patient blood serum. The GG-Test is available in compact 40-test kits. **Hyland Laboratories, 4501 Colorado Blvd., Los Angeles 39, Calif.**

For more details circle #711 on mailing card.

Tomac All-Purpose Table Adjusts for Height or Use

A versatile, attractive heavy duty folding table for use with wheel chair patients or

those seated in patient rooms, and for any other area of the hospital where a strong attractive table is needed, is available in the Tomac All-Purpose Table. Spring buttons on all four legs permit quick and easy adjustment in height to serve the particular need. Adjustment of all four legs gives a flat table for eating and other purposes, but for reading two legs are adjusted to give a comfortable sloping top with a "hide-away" bookrest. The table folds easily for storage, has a Formica top and tubular steel legs with rubber tips. **Rehabilitation Products, 2020 Ridge Ave., Evanston, Ill.**

For more details circle #712 on mailing card.

Automatic Laundry Process With Troy Washer-Extractor

A complete laundry load is processed and ready for pressing in the time usually required for washing only, with the new Troy "WX" Washer-Extractor. Standard automatic controls perform all wash and extract operations except for the manual addition of supplies. Lifting ribs assure proper washing action and two-speed extraction provides maximum moisture removal with minimum vibration. The ma-

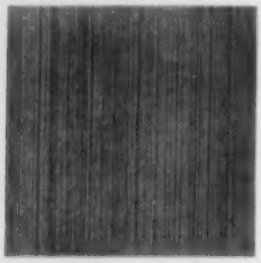
chine is available in 100 to 375-pound capacity models. **Troy Laundry Machinery Div., American Machine and Metals, Inc., East Moline, Ill.**

For more details circle #713 on mailing card.

(Continued on page 230)

Bolta-Wall Vinyl Tile Is Now Sanitized

A sanitizing process is used to treat the new Bolta-Wall vinyl tile and roll goods for wall covering. The process protects ma-



terials against the growth and action of bacteria, fungi, mildew and other microorganisms. The new material is germ, odor and mold resistant, yet is non-toxic and non-irritating. It is designed to assist in keeping patient rooms and other hospital areas as free from sources of infection as possible. The Striped Linen pattern illustrated is the first among many attractive wall covering materials available in the sanitized line. **The General Tire & Rubber Co., Akron, Ohio.**

For more details circle #714 on mailing card.

Clinitest Urine-Sugar Set in Streamlined Plastic Case

An attractive, streamlined case in two-tone gray plastic compactly holds the components of the new Clinitest Urine-Sugar Analysis Set. Fitted to form a self-contained unit, the new set has a visible test tube holder which exposes the entire length of the tube. The interchangeable refill permits the use of either Clinitest Tablets in bottles of 36 or Sealed-in-Foil tablets. Reagent tablets, test tube, dropper and color scale are standardized to Clinitest specifications for rapid, reliable urine-sugar testing. **Ames Company, Inc., Elkhart, Ind.**

For more details circle #715 on mailing card.

Mobile Cracked Ice Bin Introduced by Jewett

Cracked ice is available as needed with the new Jewett Model R-100P mobile ice bin. Mounted on two swivel and two sta-

tionary rubber-tired casters for easy movement, the counter-balanced unit holds 150 pounds of cracked ice. Exterior and bin are of stainless steel with two inches of insulation. The unit is 24 by 25 inches in size, 37 inches high. **Jewett Refrigerator Co., Inc., 2 Letchworth St., Buffalo 13, N.Y.**

For more details circle #716 on mailing card.

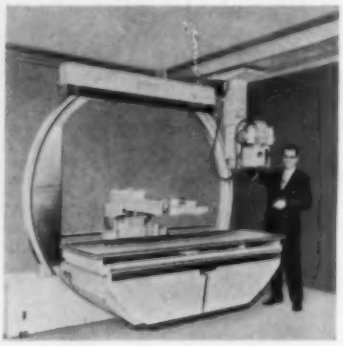
Storage Space Saved With Concentrated Tomato Juice

Convenience in handling and savings in storage space are some of the advantages offered in the new Concentrated Tomato Juice now available from Heinz. The new product is the result of extensive research by Heinz food technologists and chefs. The process used eliminates approximately 75 per cent of the water content, saving corresponding storage space. The concentrate is mixed with ice water for immediate serving of chilled tomato juice without refrigerated storage. It may also be used for cooking. **H. J. Heinz Co., P.O. Box 57, Pittsburgh 30, Pa.**

For more details circle #717 on mailing card.

G-E Imperial "Mark-II" Diagnostic X-Ray Unit

Exact counterbalancing of every function under accurate and simplified control gives the new General Electric Imperial "Mark-II" diagnostic x-ray the effect of weightlessness in use. The ease of handling permits radiologist and technician to devote undivided attention to the patient. A new concept in bilateral overhead tube-



hanger design eliminates the "pull" of high-voltage cables. The newly-designed spot-film unit retains shutter diaphragm settings regardless of table angulation. **General Electric Co., X-Ray Dept., 4855 W. Electric Ave., Milwaukee 14, Wis.**

For more details circle #718 on mailing card.

Square Dial and Round Clocks in "Flexchron" Clock System

Newly styled clocks have been developed specifically as additions to the new Standard "Flexchron" Clock and Program System. The automatic, fully-corrected clock system now employs the new square dial clocks and newly styled round clocks with markers instead of numerals. The new models, in 10, 12 and 16-inch sizes, are also supplied with other movements for use in impulse systems and as individual clocks. **The Standard Electric Time Co., 89 Logan St., Springfield, Mass.**

For more details circle #719 on mailing card.

Stainless Steel Utility Truck Has Heavy Duty Chassis

A heavy duty automotive-type chassis is used for the new stainless steel Cargo Clipper. The utility truck is designed as a strong, versatile truck for all-purpose use in food operations and for general use in the hospital. The U-type frame supports stainless steel shelves with all joints and points of strain reinforced and welded. The Cargo Clipper rolls smoothly on 6-inch Bassick wheels with dirt guards and syn-

thetic rubber tires that resist heat, acids, alkalis, grease and other hazardous liquids. The truck is easy to clean and has a load capacity of 600 pounds. **Bloomfield Industries, Inc., 4546 W. 47th St., Chicago 32.**

For more details circle #720 on mailing card.

Universal Tinting Colors for All Types of Paints

A single, safe, sure type of tinting medium which can be used with success in all types of modern primers and finishes is introduced by Barreled Sunlight Paint Company in high-strength "Universal Tinting Colors." The 15 colors were developed especially for use with the various white paints and enamels in the Barreled Sunlight Master Painter "10-Line" but they can also be used to tint any type of interior or exterior primer or finish or with ready-mixed colors for special tints, according to the report. The colors disperse quickly and completely with a minimum of stirring and have high tinting strength. The 15 colors are packaged in friction top quart and half-pint cans. **Barreled Sunlight Paint Co., Box 1365, Providence 1, R.I.**

For more details circle #721 on mailing card.

Compact Lift Helps Patients

Patients can be easily lifted in and out of automobiles from wheel chairs with the new Hoyer Kartop Lift. The device mounts on top of an automobile to help the patient in and out with one attendant and mini-

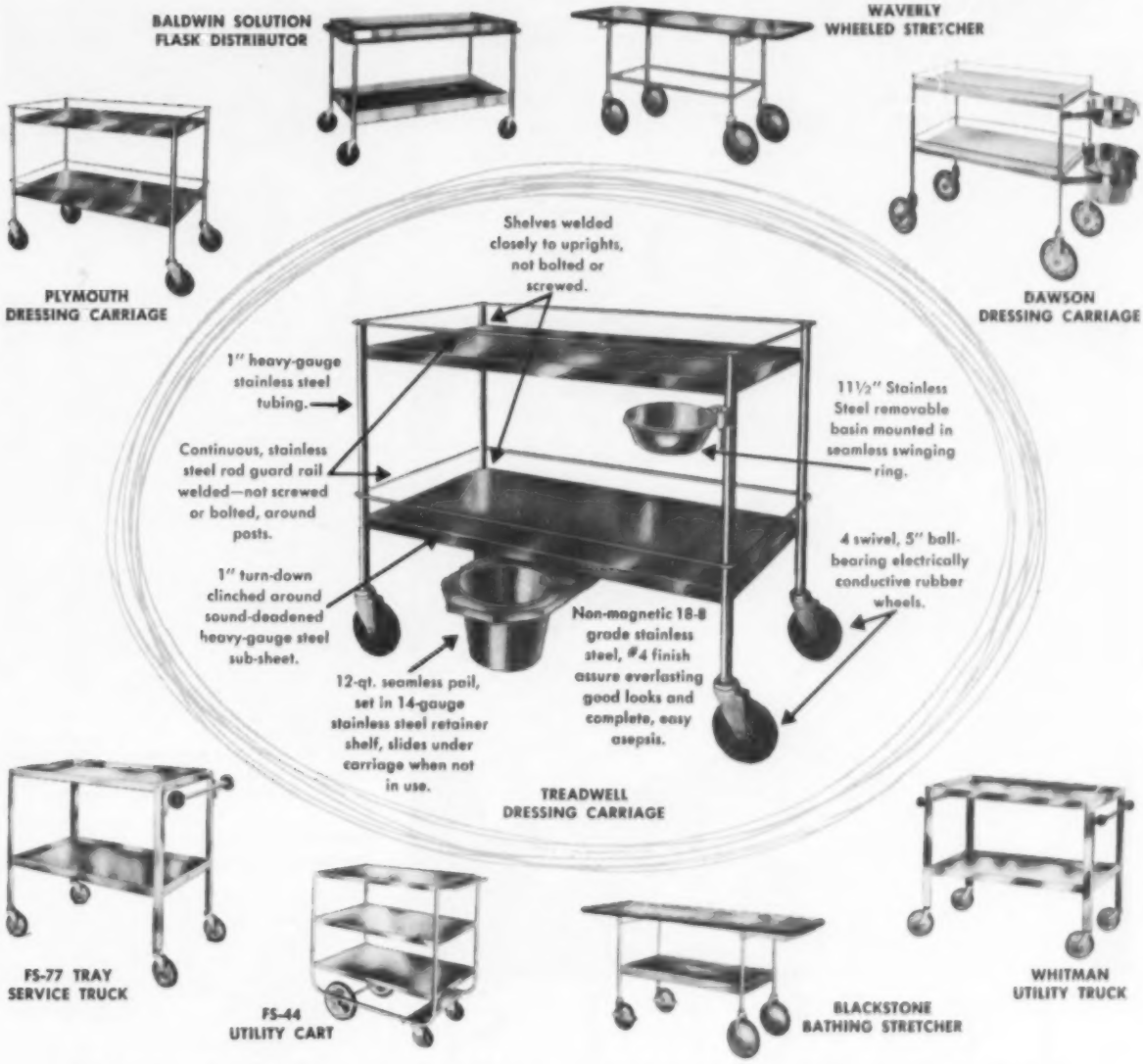
mum effort. The entire operation can be easily accomplished by a nurse or other woman attendant. **Everest & Jennings, Inc., 1803 S. Pontius Ave., West Los Angeles 25, Calif.**

For more details circle #722 on mailing card.

(Continued on page 232)

HERE'S PROOF...

Blickman Equipment is the finest ...yet it costs no more!



Blickman craftsmanship gives you the *full* benefit of stainless steel. Gauges heavy enough for hard wear. Finishes fine enough for full corrosion resistance and complete asepsis. Rounded corners... invisible seamless welds... completely crevice-free surfaces and joints—wherever required. Blickman alone delivers them all for added convenience, top performance, sure sanitation and decades of durability—*yet it costs no more!* For full details on Blickman's complete line of hospital equipment write: S. Blickman, Inc., 1506 Gregory Avenue, Weehawken, N. J.

BLICKMAN
HOSPITAL EQUIPMENT

Look for this symbol of quality... Blickman-Built

"SOLD THROUGH BLICKMAN AUTHORIZED HOSPITAL EQUIPMENT DEALERS"

Sterex Urinal Design Reduces Spillage

Chances of spillage are greatly reduced with the design of the new unbreakable

Tomac Sterex Urinal. Stability is increased and in horizontal position the Sterex has increased capacity. Combining economy and convenience with modern design, the urinal is made of high impact material which is quiet in handling and is not cold in use. It is bacteriostatic, resists odors and is easily cleaned with ordinary detergents. The translucent white urinal is graduated in both cc's and ounces and is autoclavable at 300 degrees F. **American Hospital Supply Corp., 2020 Ridge Ave., Evanston, Ill.**

For more details circle #723 on mailing card.

Easily Opened Chair-Bed for Patient Rooms and Nurses

Quick, easy opening and closing, attractive appearance, and storage space for a made-up bed with pillows are some of the features of the new Couchette Ducal Transformable unit. In addition to providing the advantage of a sitting room with comfortable, made-up bed available in seconds for nurses' homes and staff quarters, the Couchette offers special advantages in actual hospital use. The arm chair unit provides a firm, comfortable, upholstered seat for the convalescing patient from which he can rise without help or undue effort. In a matter of seconds the chair can be converted into a bed for a mother staying with a pediatric patient, a special duty nurse or other attendant, and similar uses. After use the bed is made and

straps attached at each end are pulled to bring top and seat easily together, again forming the sturdy, comfortable chair. The Couchette is available in single chair, sectional or two davenport sizes. It is balanced so that it moves readily on easy-rolling casters for floor cleaning. **Superior Sleeprite Corp., 739 S. Washtenaw Ave., Chicago 12.**

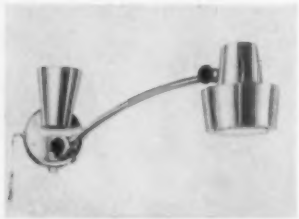
For more details circle #724 on mailing card.

Standby Electric Plant Is Also Portable

Designed for emergency standby use, or as a portable unit, the new 2500-watt Onan electric generating plant is relatively light in weight. The gasoline engine-driven generator set will serve the emergency needs of a small institution or department and is a completely self-contained versatile unit. Model 205AJ-IM/1430 standby model is compact and has a separate fuel tank. **D. W. Onan & Sons Inc., 2515 University Ave. S.E., Minneapolis 14, Minn.**

For more details circle #725 on mailing card.

Multi-Purpose Light for Patients' Rooms

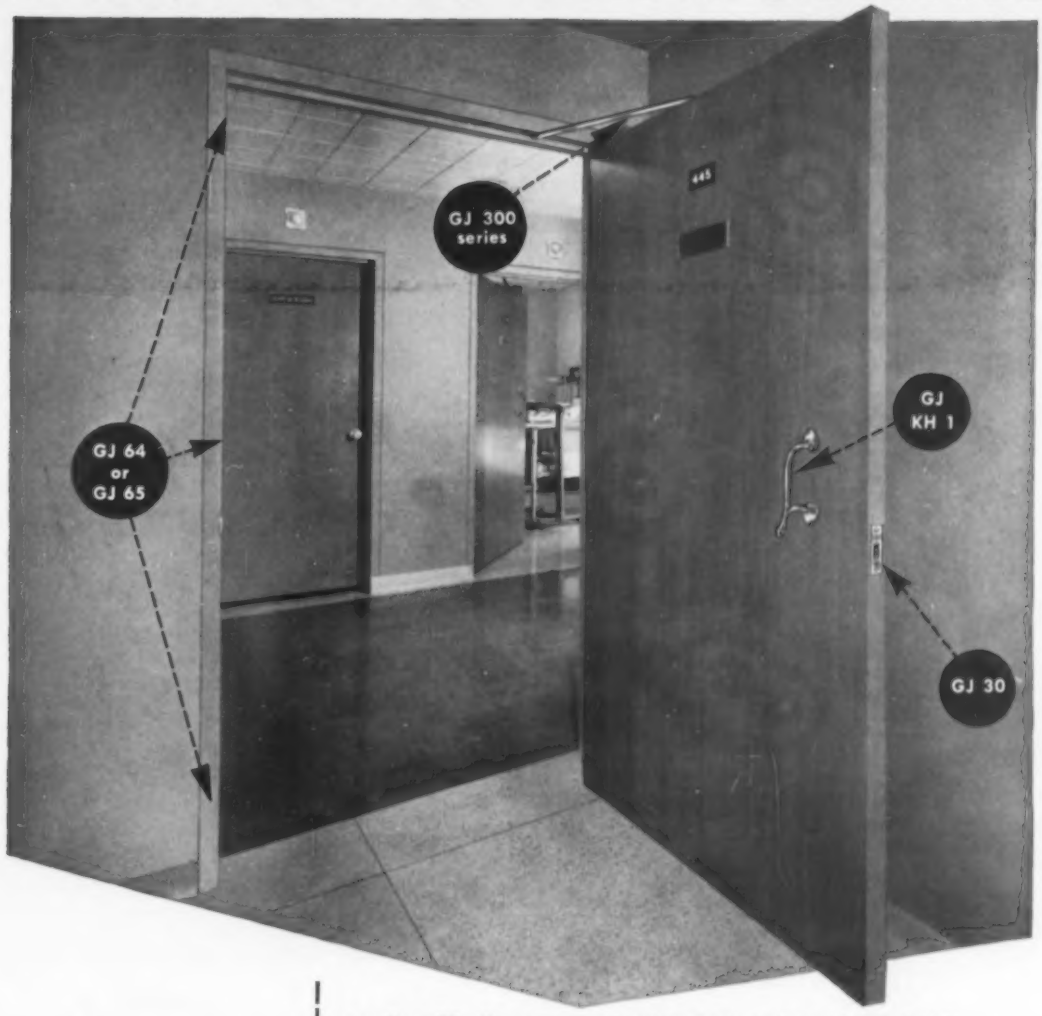


The new Model 617 Wall Light is a multi-purpose unit providing all illumination needs for the patient's room. It may be used as a reading light, for indirect room illumination, and as an examining light. The double-walled reflector is thoroughly ventilated for coolness to prevent burns and the wall canopy comes with a six-watt night light and plug-in receptacle. **Adjustable Fixture Co., 104 E. Mason St., Milwaukee 2, Wis.**

For more details circle #726 on mailing card.

(Continued on page 234)

an ideal specification for silent, efficient
PATIENT ROOM DOOR CONTROL



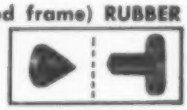
"shall have GLYNN·JOHNSON . . .

GJ 300 series CONCEALED (or surface mounted) OVERHEAD FRICTION TYPE DOOR HOLDER." (Nurse may set door at any desired degree of opening for ventilation or privacy. Door cannot slam open or shut.)

"GJ KH 1 COMBINATION HAND AND ARM PULLS to be mounted back to back as a pair." (Convenient for opening door from either side with sterile hands or when carrying loaded trays.)

"GJ 30 ROLLER LATCH." (Eliminates disturbing latch "clicking" sound. Replaceable rubber roller *silently* engages dirt-free strike. Latching pressure adjustable.)

"THREE GJ 64 for metal frame (or GJ 65 for wood frame) RUBBER SILENCERS." (Form pneumatic air pockets to absorb shock or noise of closing and create constant latch tension . . . no door rattling.)



This ideal specification for patient room doors is used in such outstanding hospitals as:

Kaiser Foundation Hospital, Los Angeles, Calif. Wolff & Phillips, Portland, Oregon — architects

Oak Park Hospital, Oak Park, Illinois Shaw, Metz and Dolio, Chicago — architects

Providence Hospital, Washington, D.C. Faulkner, Kingsbury & Stenhouse, Washington, D.C. — architects

Rhode Island Hospital, Providence, R. I. Shepley Bulfinch Richardson & Abbott, Boston, Mass. — architects

All above hardware can be quickly installed on existing patient room doors.

write for HOSPITAL DOOR CONTROL brochure E-4

GLYNN·JOHNSON CORPORATION

4422 n. ravenswood ave. chicago 40, illinois

For additional information, use postcard facing Cover 3.

Children's Game Reduces Child's Fears

A colorful game for children entering the hospital is introduced as a means of helping to overcome apprehensiveness in small patients. The game illustrates a child's typical hospital adventure from the admitting office until departure and can be played by four children. Rules, cards and space markers are included and suggestions for parents are given on the back surface. **Johnson & Johnson, Hospital Div., New Brunswick, N.J.**

For more details circle #727 on mailing card.

Battery-Powered Machine Cleans Large Floor Areas

The "Convertamatic" is a high-speed battery-powered automatic floor maintenance machine designed for cleaning large, open floor areas. One operator can lay the cleaning solution, scrub the floor, vacuum up the dirty solution and damp-dry the floor in one operation. The machine can also be used as a dry cleaner, to polish and pick up dust and loose dirt.

Four low-cost, heavy duty batteries provide power for the machine and the design permits quick-change replacement of the battery pack. A fresh set of four batteries can be installed in a matter of minutes and operates the machine approximately four hours. Pressure on brushes is fully variable and the patented "power-flo" drive propels the machine in forward or reverse without

the need for clutch or differential. The machine is also available with standard electric, gasoline or propane power. **Advance Floor Machine Co., 4100 Washington Ave. N., Minneapolis 12, Minn.**

For more details circle #728 on mailing card.

Skin Traction Bandage Uses No Adhesives

Easy application and removal without shaving, and elimination of adhesive irritation are features of "Foamtrac" skin traction bandage. Foam rubber and 100 per cent cotton backing are combined in "Foamtrac." The bandage, which is nontoxic, non-allergenic and does not tear, can be sterilized by usual methods for re-use. **CoNco Surgical Products, 38 Poland St., Bridgeport, Conn.**

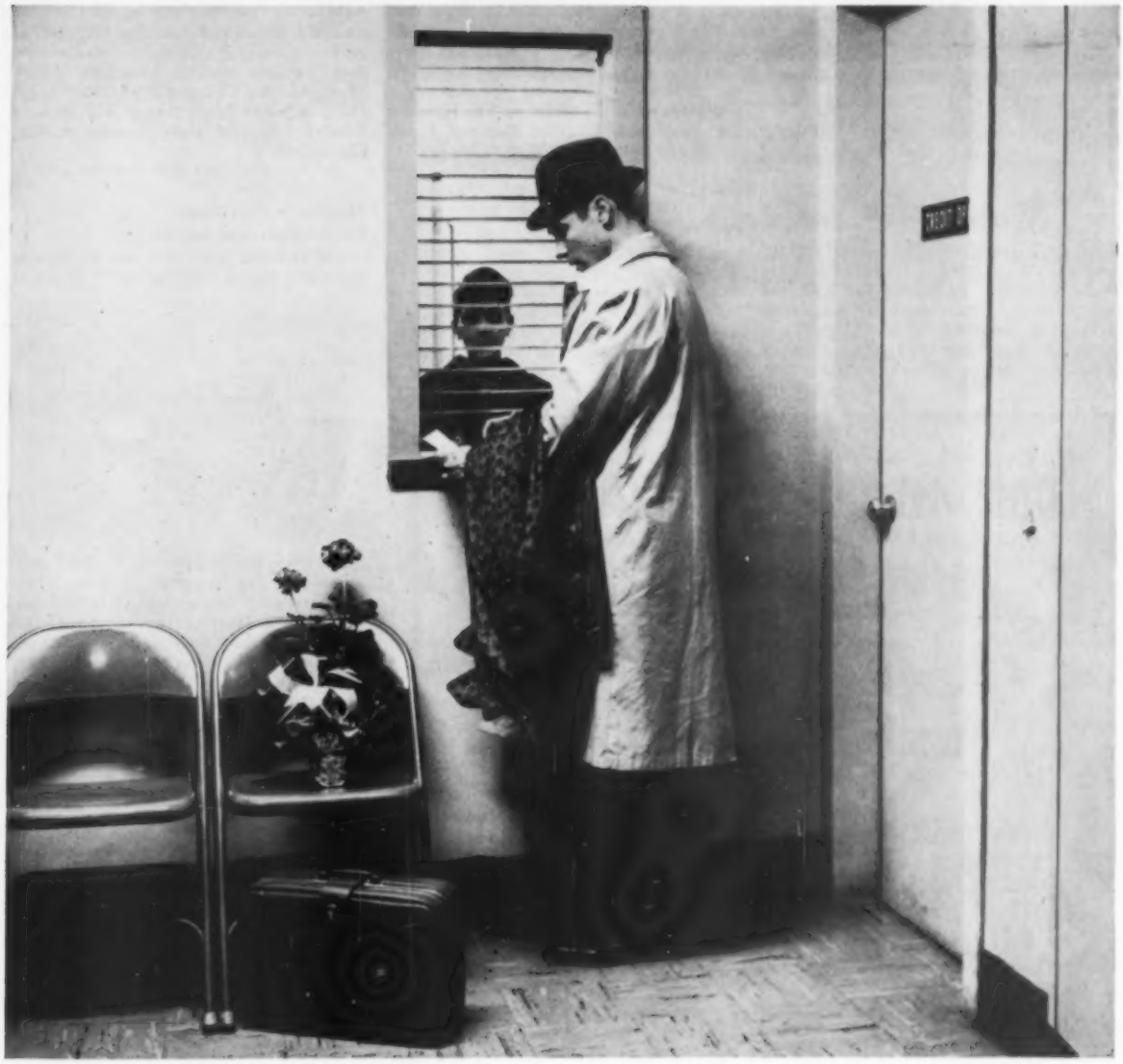
For more details circle #729 on mailing card.

Mobile Carrier for Trays and Food

The H9-6 is a Mobile Tray Carrier and Food Dispenser capable of handling six trays. Flanged edges are smoothly finished and durable and the sturdily constructed unit has stainless steel top, bottom, sides and rack slides. The tubular steel frame is chromium plated and rotary ball bearing bumpers are of non-marking rubber for rolling along walls and doors without damage. **W. H. Frick, Inc., 705 Citizens Bldg., Cleveland 14, Ohio.**

For more details circle #730 on mailing card.

(Continued on page 236)



the bill is waiting—not the patient

IBM RAMAC® 305 Provides Complete Control of Hospital Accounting Functions, Including Up-to-the-Minute Patient Billing

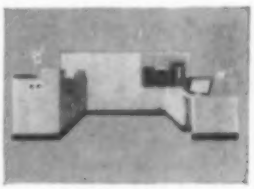
Here is a new approach to hospital accounting—one system that handles all accounting and record-keeping functions.

IBM RAMAC stores data on magnetic disks. As each transaction occurs, all affected records are posted and updated. And, through the RAMAC inquiry feature, hospital management may review any specific record.

In addition to complete control of each phase of patient billing, RAMAC gives you:

- Immediate distribution of income and expense to any number of categories.
- Complete payroll accounting.
- Current accounts receivable.
- Automatic handling of all third-party plans.
- Control of supplies inventory with recordings of issues and receipts as they are processed.
- All necessary information for budget control.
- All required data for the general ledger.

The IBM RAMAC 305 can completely modernize your entire accounting operation. Like all IBM Data Processing equipment, the RAMAC 305 may be purchased or leased. Your local IBM representative will be pleased to give you all the facts.



DATA PROCESSING **IBM**®

Self-Locking Device for Rope-Type Bags

The "Rope Hold" is a new self-locking device incorporated into the line of rope-

type bags introduced by The Hartford Company. Opening and closing of laundry bags is speeded and simplified with the new device which is attached to the strong nylon rope used with the new bags. When closed, bags automatically lock, providing a secure closure for even the roughest handling or washing conditions. A slight pull on the finger ring releases the "Rope Hold" when desired. Designed to withstand moisture, heat and washer agitation, the device cannot crack or chip, has rounded edges and cannot damage tumblers. **The Hartford Co., 21 Thomas St., East Hartford, Conn.**

For more details circle #731 on mailing card.

Sandwich Provisions Packed Bread Size

Uniform packaging of canned provisions for sandwich making is now offered by Armour. The new packaging is tailored to meet the precise size requirements for food service. The re-designed containers measure four inches square on the ends and contain a uniform six and one-half pounds of meat. They are the size of the modern sandwich bread loaf, speeding the work of sandwich making. Available in the new packages are Spiced Luncheon Meat, Chopped Ham, Chopped Pork, Pickle Loaf, Old Fashioned Loaf, Boloaf and Hickory Smoked Chopped Ham. **Armour & Co., Chicago 90.**

For more details circle #732 on mailing card.

Medikit Is Fast Test for Antibacterial Sensitivity

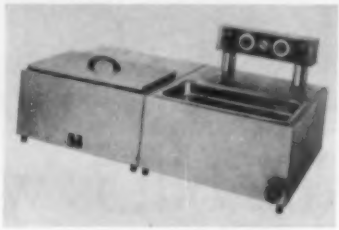
Antibacterial sensitivity can be quickly and easily tested with the new Medikit. It

is an economical, disposable culture technic for use in the patient's room which brings results usually within 12 to 24 hours. Medikit was developed by physicians as a simple laboratory technic for hospital use without the need for special laboratory equipment. Each kit contains blood agar plates, cotton-tipped applicators and rings containing eight antibacterial agents. **Media, Inc., Newark 2, N.J.**

For more details circle #733 on mailing card.

Pel-Sonic Washer Also Dries Instruments

Ultrasonic energy powers the new Pel-Sonic Washer and Instrument Dryer for effective, speedy and simplified cleaning of instruments. The all-purpose cleaner com-



bines washer and dryer in a lightweight, compact and economical unit. Complete with control panel, the machine occupies only 36 by 21 inches of space and requires no water cooling, plumbing connections or special wiring. **The Pelton & Crane Co., Charlotte 3, N.C.**

For more details circle #734 on mailing card.

Plastic Needle Packages Provide Instant Identification

Instant identification of needle type and quantity is provided with the new transparent plastic needle package designed to hold six surgical needles. The outer envelope carries an identifying label listing needle type, quantity and style number, while the inner package protects the needles until used. **The Torrington Co., Surgical Needle Div., Torrington, Conn.**

For more details circle #735 on mailing card.

(Continued on page 238)

Drainage Collection Unit Forms a "Closed System"

The Bardic Bedside Bag for collecting and disposing of the urine of patients on

drainage consists of an inexpensive plastic bag and special hanger that slips over the side rail of bed or stretcher without protruding or interfering. There is nothing to break or tip, nothing on the floor to interfere with housekeeping, and the problem of ascending infection and odor is reduced since the sterile bag forms a "closed system." **C. R. Bard, Inc., Morris & Webster Aves., Summit, N.J.**

For more details circle #736 on mailing card.

Plastic Disposable Syringes With or Without Needles

Precision made of Cymac plastic, the new Vim Disposable Syringes are available with or without needles, individually packaged and sterilized for immediate use. The danger of cross-infection through re-use of syringes or needles is eliminated although the syringes may be used with regular needles if desired. Features include easy-to-read markings, a flat plunger end for accurate dosage, transparent Luer tip and contoured plunger head and grip. **American Cyanamid Co., Surgical Products Div., 30 Rockefeller Plaza, New York 20.**

For more details circle #737 on mailing card.

Fully Automatic Entrance Is Complete Package

Door, frame and operating mechanism are designed as an integral part of the completely automatic electric entrance package developed by Kawneer. The entire operat-

ing mechanism is contained within the trim 2½-inch wide transom bar above the door. Panic exit protection is built into the unit and a protector-type design prevents finger-pinching. The door automatically slows down near the end of each opening and closing cycle to prevent accidents. The door can be used between departments to facilitate carrying trays, instruments and other items without having to touch the door, or at the entrance for convenience and safety. **Kawneer Co., Niles, Mich.**

For more details circle #738 on mailing card.

Norelco Image Intensifier Permits Daylight Fluoroscopy

The new 9-inch Norelco image intensifier provides greatly increased intensity,

making daylight fluoroscopy practical. Images up to 1500 times brighter are claimed for the new wide-screen unit providing a 63 square-inch field for observation. The dosage now required to produce intensified images in a lighted room is but a fraction of that previously needed, permitting fluoroscopy to be carried on with a minimum of scanning. The large diameter screen accommodates images of entire areas rather than one organ. One or two observers may view at the same time, and simultaneous recording of images on 35 or 16mm film is possible. **North American Philips Co., Inc., Medical & Dental Div., 525 W. 52nd St., New York.**

For more details circle #739 on mailing card.

(Continued on page 240)

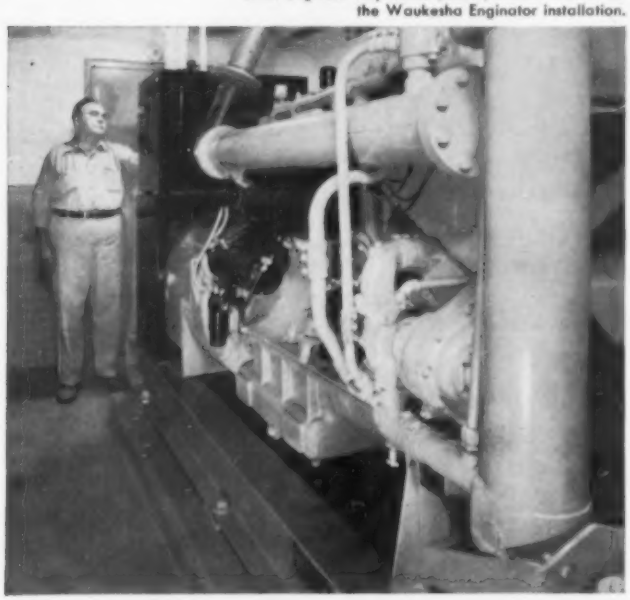
IN AN EMERGENCY

AUTOMATIC, IMMEDIATE electric SERVICE

For—essential lighting . . . surgery suite . . . laboratories . . .
X-ray . . . dietary . . . boiler rooms . . . emergency elevators . . . and ancillary equipment

Air view of Waukesha Memorial Hospital.

Chief Engineer Ray Miller *(below)* checks controls on the Waukesha Enginator installation.



Emergency electric service for the Waukesha Memorial Hospital, Waukesha, Wisconsin, is supplied by a Model WAK Waukesha Enginator—125 KW or 156 KVA, 240-volt, 3-phase, 60-cycle, at 1200 rpm—for operation on gas, with LP-Gas as a standby fuel.

Backed by over 50 years of building heavy-duty engines and electrical equipment, Waukesha Enginators (engine-generator combinations) have a world-wide proven record of reliability. Made in Diesel and carburetor fuel models, up to 800 KW capacity.

Send for descriptive literature.

433

WAUKESHA ENGINATOR®

Special Products Division
WAUKESHA MOTOR COMPANY, WAUKESHA, WIS.
New York • Tulsa • Los Angeles

AMBU Portable Kit for Respiratory Emergencies

Developed in Denmark, the new AMBU resuscitation-suction kit is a portable unit comprising a hand-operated resuscitator and a foot-operated suction pump in a sturdy carrying case. No time is required for set-up of the unit and the suction pump has an accordion bellows activated by a strong stainless steel spring for foot operation. The resuscitator has an anesthesia-type breathing bag with a special foam rubber lining which inflates the bag, a non-rebreathing valve, face mask and Berman airways of different sizes. **Air-Shields, Inc., Hatboro, Pa.**

For more details circle #740 on mailing card.

Colored Chart Tabs Simplify Record Keeping

Standardization of patients' charts and immediate location of medical reports are facilitated by the new set of nine color-tabbed Chart Dividers developed by Physicians' Record Company. Each divider has a colored plastic tab labeled for a specific type of medical record, such as Graphic Chart, Nurses' Notes, Physicians' Orders and the like. Records can be located by color or name and dividers are made to fit chart holders but may be punched for other types of holders. **Physicians' Record Co., 161 W. Harrison St., Chicago 5.**

For more details circle #741 on mailing card.

Ultraviolet Microscope Permits Visual Focusing

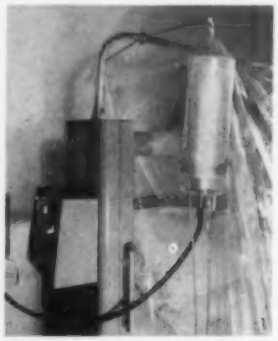
The new RCA "ultrascope tube" incorporated into the Bausch and Lomb ultra-

violet microscope permits visual focusing. Developed as a result of cooperative research on the part of both Bausch & Lomb and the Radio Corporation of America, the new B&L U-V Photo-Microscope is designed for wide application in medical research. The ultrascope tube is an electronic component capable of receiving an ultraviolet image at one end and converting it to a visible image, to be viewed under magnification, at the opposite end. The compact, practical instrument is reasonably priced and occupies only minimum space in the laboratory. **Bausch & Lomb Optical Co., Rochester 2, N.Y.**

For more details circle #742 on mailing card.

Oxygen Humidifier For Any Type Tent

The new Selas Oxygen Humidifier is a cylindrically shaped, plastic-encased por-



celain unit which produces moisture particles of only three to five microns when it is wetted with distilled water and oxygen is forced through its extremely fine pores. Designed to speed recovery of patients from various types of lung and heart surgery, and for pediatric patients, the microporous porcelain element is applicable with any standard oxygen tent. **Selas Corp. of America, Dresher, Pa.**

For more details circle #743 on mailing card.

(Continued on page 244)

For additional information, use postcard facing Cover 3.

Note: the new M-S-A Pulmonary Ventilator provides both dilution and 100% oxygen. It is sold only on the prescription of a licensed physician or on the order of properly qualified hospitals and other institutions.

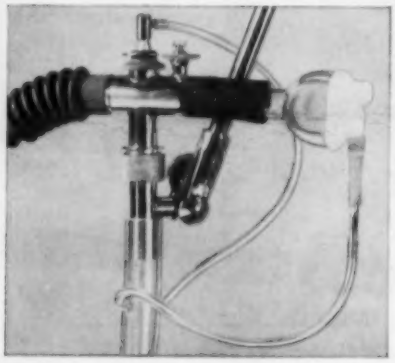
For the efficient and simplified administration of I. P. P. B. I. therapy . . . the improved M-S-A® Pulmonary Ventilator

The improved M-S-A Pulmonary Ventilator provides effective pressure breathing therapy in combination with aerosol therapy.

Clinically proven, this instrument effectively distributes aerosols such as bronchodilators, detergents and bacteriostatic agents throughout the respiratory tract. Equipped with new easy-to-clean, maintenance-free exhalation valve assembly. Operates from either a piped system or an oxygen cylinder.

Ease of operation permits quick, efficient application in hospitals, doctors' offices or in the patient's home under the physician's directions. Produces dramatic relief for most patients suffering from Emphysema, Asthma, Silicosis and similar diseases. May we *demonstrate* these and other advantages of this unit?

Write for descriptive new bulletin



MSA SAFETY EQUIPMENT HEADQUARTERS

MINE SAFETY APPLIANCES COMPANY
201 North Braddock Avenue
Pittsburgh 8, Pennsylvania

MSA . . . where safety problems become safety products through research

Grant cubicle hardware* works quietly and well. It is made of the highest quality materials and will operate efficiently under all conditions.

*Noiseless nylon rollers/suspended or ceiling track/all accessories. For full information, write to Hospital Equipment Division.

GRANT CUBICLE HARDWARE

Grant Pulley & Hardware Corporation
69 High Street, West Nyack, New York
944 Long Beach Ave., Los Angeles 21, California

It's standard practice in outstanding hospitals to choose

EDWARDS SIGNALING SYSTEMS for efficient operation

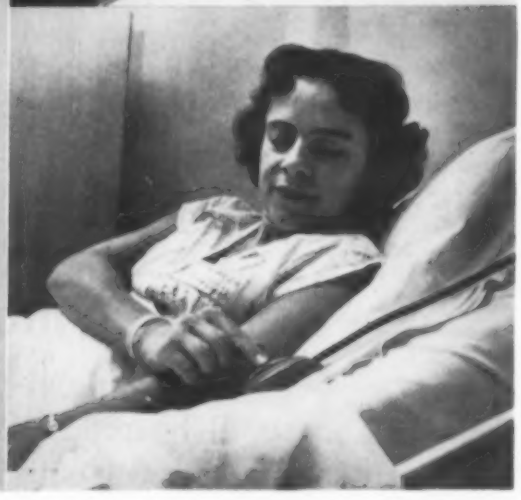
Nurse Mary Lou Barton answers a call from a patient at the Edwards Nurses' Call Master Station in Mercy Hospital.

Operating a hospital efficiently, economically, and maintaining expected high standards is no easy job. We recognize this problem because Edwards has been helping hospital administrations solve their operating requirements and achieve greater efficiency since electrical systems were introduced. Mercy Hospital in Toledo, Ohio and Fisher-Titus Hospital in Norwalk, Ohio, are typical of the many modern hospitals now using dependable, moderately-priced Edwards equipment in their operation.* In these hospitals, Nurses' Call Systems, Silent and Audible Paging Systems, Fire Alarms, Doctor's In & Out Registers and synchronous dual-motored Clock Systems are on the job day and night, guaranteeing the safe and smooth running routine demanded by the management.

A doctor's code being flashed on an Edwards Paging Annunciator at Fisher-Titus Hospital.

Edwards Doctors' In & Out Register and Edwards Flush-Mounted 12" Clock above main switchboard at Fisher-Titus Hospital. Operator is placing call on Edwards Silent Paging System.

Mr. Howard W. Sallabank, Chief Maintenance Engineer, inspects a station of an Edwards Fire Alarm System protecting Fisher-Titus Hospital. Above is Edwards Fire Alarm bell.



Mrs. V. Hiller demonstrates fingertip operation of a new type Edwards "Sta-put" Nurses' Call Button at Mercy Hospital.

If you would like to learn more about the many ways Edwards Signaling Systems can make your hospital safer, more convenient in routine, most efficient in operation, write Edwards, Dept. MH-6, or call the nearest Edwards sales office. There's never any obligation—so why not write or call today.

*Your local Edwards representative will be glad to provide the names of hospitals in your area currently using Edwards equipment.

EDWARDS

Specialists in signaling since 1872

Edwards Company, Inc., Norwalk, Connecticut
(In Canada: Edwards of Canada, Ltd, Owen Sound, Ontario)

For additional information, use postcard facing Cover 3.

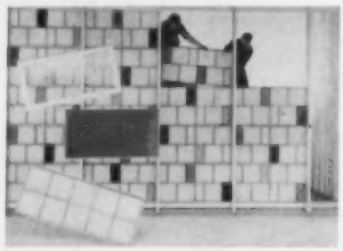
Unusual Design For Overbed Table

An all aluminum table of unusual design, with a wood-grain solid plastic top, was recently introduced by Beam Metal Specialties. The "Beam-Matic" Table may be used for chair or bed feeding and may be tilted from either side. It has ball bearing casters and may be adjusted in height from 30 to 46 inches. **Beam Metal Specialties, 25-11 49th St., Long Island City 3, N.Y.**

For more details circle #744 on mailing card.

Attractive Colors Now in Thinlite Curtain Walls

The Thinlite Curtain Wall System now offers two new rectangular glass tile shapes and eight ceramic, fired-on colors for interesting and attractive wall construction. The modular panels in the system are two inches thick, providing both an inside and outside finished wall, with extruded aluminum inter-locking perimeters secured to struts by a simple bolt-assembly. Horizontal and vertical rectangular shapes supplement the square shape originally developed. In addition to the three basic panel tints, new ceramic colors include Chinese red, golden yellow, indigo, bronze, turquoise green, peacock blue, charcoal gray and ebony, permitting a wide choice in planning. The Thinlite System permits speedy erection of



buildings with completely finished interior and exterior walls. **Owens-Illinois, Toledo 1, Ohio.**

For more details circle #745 on mailing card.

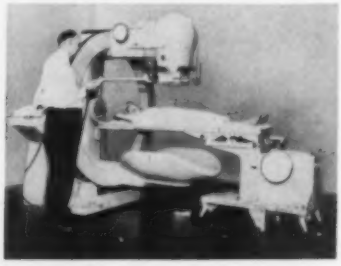
Disposable Cartridges Have Plastic Casings

Inert durable plastic now forms the casing, top and bottom caps, and grids for the disposable cartridges used in the Barnstead Bantam Demineralizer. The possibility of rusting and metallic contamination are eliminated and the color-coded cartridges come in the standard layer-type and mixed-bed high purity-type. Oxygen removal and organic removal cartridges, as well as cartridges charged with cation resin only are also available in plastic. **Barnstead Still & Sterilizer Co., Lanesville Terrace, Boston 31, Mass.**

For more details circle #746 on mailing card.

Cobalt Teletherapy Unit is Radioactive Isotope

All moving-beam technics performed with the new Keleket-Barnes Mark II



Rotaray Cobalt Teletherapy unit are automatic, electrically selected by control settings. Facilities for both moving-beam rotational therapy and a complete range of stationary multiple portal technics are provided in the new radioactive isotope machine designed specifically for the administration of Cobalt 60 radiation to deep seated lesions and tumors. The completely redesigned source shield far exceeds recommended protection requirements with electrical elements located within the unit, saving space in the treatment room. **Tracerlab Keleket, 1601 Trapelo Rd., Waltham 54, Mass.**

For more details circle #747 on mailing card.

(Continued on page 248)

Libbey Esquire Tumblers offer

4 Big Advantages...

1. "Safedge" glass is guaranteed: "A new glass if the rim of a Libbey 'Safedge' glass ever chips!"

2. Curved side wall design bulges slightly near top, protects rim if glass is turned over.

3. Heavy base, handsome mannish design, make Esquire glasses easy to hold.

4. Esquire Tumblers are available plain or fluted in a complete range of eight sizes.

The attractive shape of Esquire Tumblers adds a distinctive touch to beverage service, and every glass can be decorated with your emblem or motif for added prestige. Esquire assures operating economy, too, because of its amazing durability.

Libbey is the exclusive choice of leading restaurants because it combines customer-pleasing beauty with management-pleasing durability and economy.

For full information on Esquire and all the other economical Libbey patterns, see your Libbey Supply Dealer, or write to Libbey Glass, Division of Owens-Illinois, Toledo 1, Ohio.

Collins
No. 42770, 12-oz.
(Old No. 259)

Collins
No. 42730, 11-oz.
(Old No. 226)

Hi-Ball
No. 42620, 9-oz.
(Old No. 225)

Hi-Ball
No. 42570, 8-oz.
(Old No. 232)

Split
No. 42500, 7-oz.
(Old No. 223)

Seltzer
No. 42450, 6-oz.
(Old No. 251)

Side Water
No. 42380, 5-oz.
(Old No. 249)

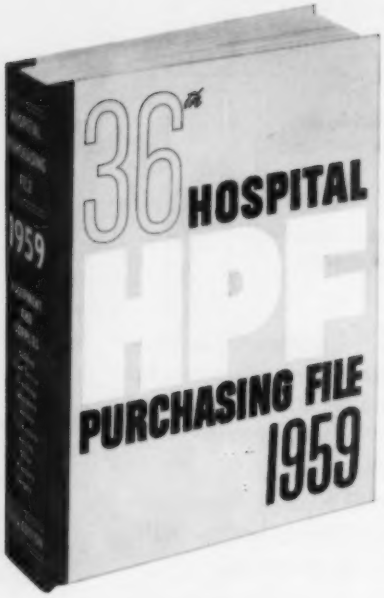
New Fashioned
No. 42490, 7-oz.
(Old No. 227)

Can be crested with your own crest, trademark, or slogan for added distinction.

LIBBEY SAFEDGE GLASSWARE
AN (O) PRODUCT

OWENS-ILLINOIS
GENERAL OFFICES • TOLEDO 1, OHIO

serving hospital buyers since 1919



makes it

so much easier

to find, compare, select

the products you buy —

occasionally or routinely

a service of F.W. DODGE CORPORATION

PUBLISHED BY PURCHASING FILES, INC., 919 NORTH MICHIGAN AVE., CHICAGO 11, ILL.

Seven-Up's "SECOND LABEL" should be your FIRST THOUGHT

Purity was never more self-evident. The back of every 7-Up bottle proves it. On this "second label" an ingredients listing proudly tells what 7-Up contains. Nothing more, nothing less.

Water treated to be colorless, odorless, tasteless; then carbonated. *Sugar* that meets standards more rigid than those for table sugar. *Citric acid*, the natural acid present in citrus fruits. *Sodium citrate* to help develop the fresh, clean taste of 7-Up. *Natural oils* pressed from fresh lemon and lime peel, and super-refined to select and concentrate only the most desirable parts of their pure, natural flavors.

Seven-Up is exactly what our "second label" says it is . . . finest quality which you may recommend with confidence.

Nothing does it like Seven-Up!

Combination Cabinet Fills O.R. Needs

An x-ray viewing box, an instrument cabinet and a storage cabinet are combined in a new built-in stainless steel operating room unit introduced by Blickman.

The instrument storage section fills the left half of the cabinet and has five adjustable glass shelves with a locking door. The x-ray viewer in the upper right half of the cabinet is equipped with an explosion-proof switch and two 15-watt fluorescent daylight tubes. The storage section has a stainless steel adjustable shelf and a sound-deadened door. Hinges are semi-recessed and the 18-inch deep cabinet is 66 inches high and 48 inches wide. **S. Blickman, Inc., 8400 Gregory Ave., Weehawken, N.J.**

For more details circle #748 on mailing card.

Specialized T & S Line of Laboratory Service Fixtures

The T & S high quality standards are built into the comprehensive new line of laboratory service fixtures recently introduced. The highly specialized "Lab-Flo" line supplies every laboratory fixture requirement. It includes fixtures, hose cocks, remote controls and combination units for water, steam, gas, air and other elements. Specifically designed and engineered for laboratory service, the "Lab-Flo" line features heavy duty construction and extra heavy chrome plating. **T & S Brass & Bronze Works, Inc., Westbury, L.I., N.Y.**

For more details circle #749 on mailing card.

Disposable Urinal Assures Sanitation

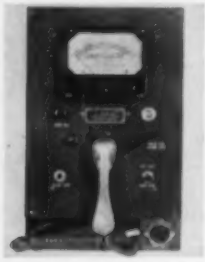
Vinyl plastic coating on the inside of the Sanivoid discardable urinal makes it liquid tight and odor resistant. Thoroughly

tested in hospital use, the Sanivoid is formed of commercially sterile paper stock. Space is provided for patient information on the economic unit which is used by one patient and then discarded. The Sanivoid is designed to stand firmly without spilling and the convenient handle is placed to avoid spilling while it is carried. It is light and easy to handle, does not get cold, and is physically safe for use in psychiatric wards. **Sealright Pacific, Ltd., 4209 E. Noakes St., Los Angeles 23, Calif.**

For more details circle #750 on mailing card.

Portable Conductometer for Electrical Resistance Tests

Electrical resistance of personnel, flooring and equipment in operating rooms can now be tested without remodeling with the new portable Conductometer Model H 90-



500A. The portable type model is enclosed in a metal cabinet and may be set up in the operating room, delivery room and emergency room as required. The complete unit comprises electrically operated testing instrument, test plates and testing electrodes. **Conductive Hospital Accessories Corp., 82 W. Dedham St., Boston 18, Mass.**

For more details circle #751 on mailing card.

Portable Coffee Unit Provides Complete Service

A vacuum-insulated coffee carrier-dispenser, portable stand, plug-in automatic heating unit and a dispenser for paper hot cups comprise the new "AerVoid" portable coffee unit. Developed for use in locations where there is no coffee service, the unit provides complete facilities. **Vacuum Can Co., 19 S. Hoyne Ave., Chicago 12.**

For more details circle #752 on mailing card.

Acoustical Ceiling Tile Has Fissured Stone Design

Nu-Wood® Micro-Perf is the name given to a new acoustical ceiling tile with a fissured stone effect. Pin-point perforations flare into bell-shaped cavities beneath the surface for effective sound reducing efficiency but the fissured design makes the small holes unoticeable. The new design is available in gray or beige on a non-glare white tile surface. **Wood Conversion Co., First National Bank Bldg., St. Paul 1, Minn.**

For more details circle #753 on mailing card.

(Continued on page 250)

A continuing series of distinguished schools, churches, hospitals, office buildings and industrial structures using NORTON DOOR CLOSERS

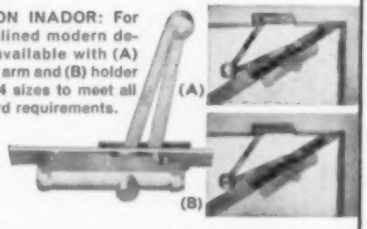
ARCHITECT: ELLERBE & COMPANY, ST. PAUL • HARDWARE DISTRIBUTOR: FARWELL, OZMUN, KIRK & CO.

MOST MODERN IN RESEARCH EQUIPMENT ...AND IN DOOR CLOSERS

New Graphic Products Building for Minnesota Mining and Manufacturing Company has NORTON Door Closers specified throughout

Complete Norton Line Meets Every Door Closer Need

NORTON INADOR: For streamlined modern design; available with (A) regular arm and (B) holder arm...4 sizes to meet all standard requirements.



NORTON 750: New corner design with concealed arms, for all types of doors, particularly narrow-rail doors.

NORTON SURFACE-TYPE: For all installations where concealment is not essential.

NORTON 703-N Compact surface-mounted type... 1⅛ inch projection.

Norton Door Closers were specified for this distinguished structure because of their outstanding record of proved dependability. Where concealment was desired, Norton INADOR Closers were chosen for complete harmony with the clean-lined contemporary design of doors.

Inador's rugged mechanism fits snugly inside a mortise in the top rail of any 1¾" door, or can be used on 1⅜" doors by taking a full cut out of top rail and applying special side plates. Despite this extreme compactness, however, Inador is a true liquid-type closer with all the reliability, low maintenance and precision workmanship characteristic of all Norton products. For complete data on these and all other Norton models, consult the current Norton Catalog #57. Write for it today.

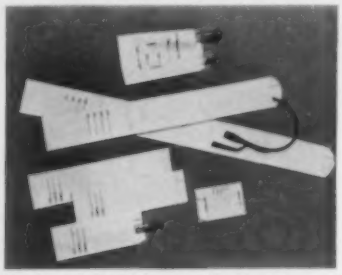
NORTON® DOOR CLOSERS

Dept. MH-69, Berrien Springs, Michigan

For additional information, use postcard facing Cover 3.

Disposable Sterilization Bags Are Inexpensive and Non-Indicating

High standards and specifications are built into the new complete line of non-



indicator disposable sterilization bags developed by A.T.I. The inexpensive bags are designed in the standard range of sizes for sterilization of infant formula bottles, syringes, catheters, needles and other surgical instruments. **The Aseptic-Thermo Indicator Co., 11471 Van Owen St., North Hollywood, Calif.**

For more details circle #754 on mailing card.

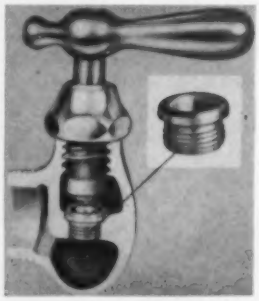
Automatic Temperature Control on Toastmaster Sink Sanitizer

Sink water temperatures are automatically maintained from 80 to 190 degrees F. with an electric heater which fits any sink 13 by 13 inches or larger. Designed for use where automatic dish and pot washing facilities are not available, the new Toastmaster Sink Sanitizer is attached to the top of the sink backsplash by means of an adjustable mounting clamp, the "U" shaped single plane element resting firmly on the sink floor. The control box is completely closed and shielded and the unit has a low-water shut-off. **Toastmaster Div., McGraw-Edison Co., Elgin, Ill.**

For more details circle #755 on mailing card.

Removable Faucet Seat Reduces Maintenance Costs

The Sexauer Removable Full-Saddle Seat is designed to reduce water, fuel and main-



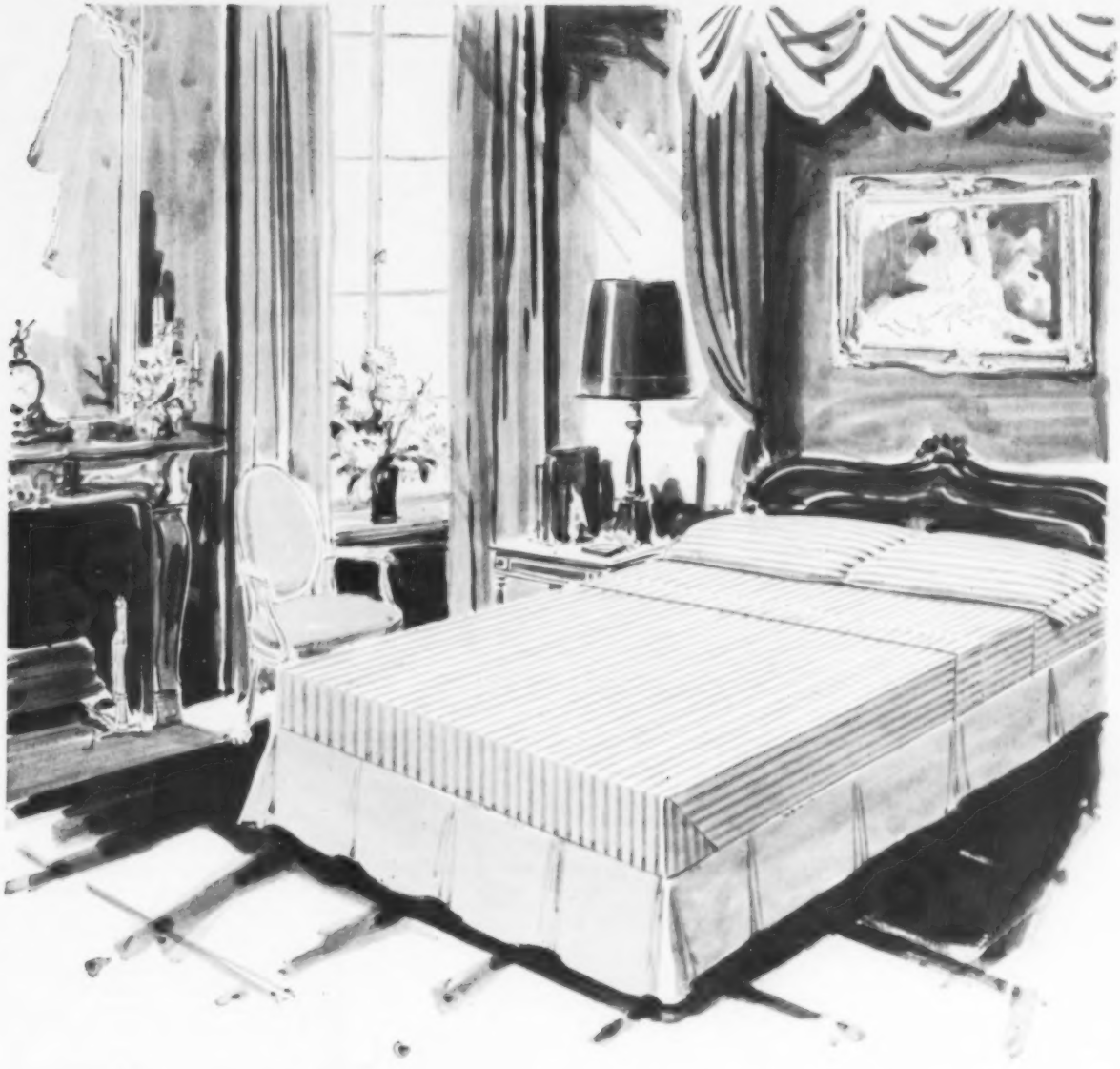
tenance costs while prolonging faucet life. Made of Monel, the rustproof, corrosion resistant seat has special contours providing a maximum of smooth seating area, eliminating the possibility of the washer being deeply grooved. The "full-saddle" contour ensures maximum water flow and in closing the faucet, a tight, positive seal is ensured, reducing wear on faucet threads, spindle and washer. The new Faucet Seat is available in ten models, designed to fit most makes and types of faucets. **J. A. Sexauer Mfg. Co., Inc., 2503 Third, New York 51.**

For more details circle #756 on mailing card.

(Continued on page 252)

Use Stevens Utica-Mohawk Striped Sheets

For Glamorous Bedrooms . . . That Are Practical, Too



Add distinction to your bedrooms the way many of America's finest hotels have already done: specify Utica-Mohawk single color or multi-color *striped* muslin and percale sheets □ Utica-Mohawk striped sheets transform an average bedroom into something very special. And they give extra value, too! Strict quality controls assure unsurpassed smoothness, firmness and strength. Stevens Exclusive Delta Finish® means brilliant whiteness, clear true colors, long-wearing beauty. Good reasons why Utica-Mohawk sheets *lead all others* in sales to hotels, hospitals, motels and other institutions. □ Stevens Utica-Mohawk weaves four sheet types (Utica® 140, Utica-Mohawk® 180, Beauticale® 200, Utica-Mohawk 150) in a wide selection of styles: flat, fitted, bleached, colored, striped, printed, regular hems, reversible hems, stamped identification, bonnazed, kaumagraphed. □ Overnight shipments, unequaled service from leading contract distributors equipped with complete stocks. Write to us today.

Stevens Utica Stevens Mohawk Sheets

Fine Fabrics Stevens Since 1813

J. P. STEVENS & CO., INC., STEVENS BUILDING, BROADWAY AT 41st ST., NEW YORK 36, N. Y.

Pharmaceuticals

Rubramin PC

Rubramin PC is a new form of vitamin B_{12} for injection intramuscularly, subcutaneously or intravenously. It is effective in the treatment of complicated or uncomplicated pernicious anemia, megaloblastic anemias and other disorders where vitamin B_{12} is indicated. It is supplied in varying strengths in vials. **E. R. Squibb & Sons, 745 Fifth Ave., New York 22.**

For more details circle #757 on mailing card.

Actase Fibrinolysin (Human)

Actase Fibrinolysin (Human) is a naturally derived fraction of human blood for intravenous dissolution of blood clots in cases of pulmonary embolism and thrombophlebitis. It produces and maintains an active introvascular fibrinolytic system in patients with thromboembolic disorders by its enzymatic action on the fibrin content of a blood clot. Actase is supplied in vials for administration as an intravenous infusion in fluid. Vials must be stored at 0 to 10 degrees C. **Ortho Pharmaceutical Corp., Raritan, N.J.**

For more details circle #758 on mailing card.

Endrate Disodium

Endrate Disodium is a synthetic compound which unites with cations to form chelates, or ring compiexes. It is indicated in the treatment of pathologic calcification and clinical reports show a beneficial action in the management of intractable angina pectoris, scleroderma and porphyria, and in the treatment of digitalis intoxication. It is administered by intravenous infusion. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #759 on mailing card.

Daricon Tablets

Daricon Tablets are a potent, long-acting cholinergic for the treatment of peptic ulcers of the duodenal, gastric and marginal types, functional bowel syndrome, and certain other gastrointestinal and genitourinary disorders. They combine potent gastric antisecretory, antispasmodic and antimotility activity with long duration of action. Daricon white scored tablets are supplied in bottles of 60 and 500. **Pfizer Laboratories, 620 Flushing Ave., Brooklyn 6, N.Y.**

For more details circle #760 on mailing card.

Ionamin

Ionamin, available in two strengths, provides a non-amphetamine appetite curb where appetite appeasement only is required in weight loss. When used as directed, it assures predictable weight loss and may be prescribed for obese patients who are arthritic, diabetic, pregnant, menopausal, aged and to reduce surgical risks. **Strasenburgh Laboratories, P. O. Box 1710, Rochester 3, N.Y.**

For more details circle #761 on mailing card.

Enarax

Combining oxyphencyclimine hydrochloride, an anticholinergic or gastro-intestinal nerve blocking agent, with the tranquilizer Atarax, the new Enarax tablets are designed for use in the management of peptic ulcers and related gastrointestinal disorders. They are supplied in bottles of 60 tablets. **J. B. Roerig & Co., 800 Second Ave., New York 17.**

For more details circle #762 on mailing card.

Literature and Services

• A comprehensive product catalog on surgical sutures is available from Ethicon, Inc., Somerville, N.J. Interesting illustrations showing use of the sutures, Atraloc needles, foil packages and other materials are presented, together with full descriptive information, in the plastic-bound, hard cover. **"Ethicon Descriptive Suture Catalogue."**

For more details circle #763 on mailing card.

• **"4 Versatile Office Time-Savers"** are illustrated and described in the new 16-page booklet available from Eastman Kodak Co., Business Photo Methods Div., Rochester 4, N.Y. The booklet tells why and how the four modern copying machines developed by Eastman Kodak can save time and money and increase efficiency for the user.

For more details circle #764 on mailing card.

• Colorful illustrations of **Natco Structural Clay Products** and photographs of installations are shown in Natco **Catalog S-59** available from Natco Corp., 327 Fifth Ave., Pittsburgh 22, Pa. Detailed drawings, specifications and descriptive information on these products for interior and exterior walls are presented, with data on other clay products manufactured by the company.

For more details circle #765 on mailing card.

• A chart containing concise pictorial information on diapering and tips on the prevention and treatment of diaper rash is offered by Chesebrough-Pond's Inc., 485 Lexington Ave., New York 17. Entitled "How To Be a Quick-Change Artist," the chart is designed for teaching and for distribution to new mothers.

For more details circle #766 on mailing card.

• **"This Emblem Could Save Your Life"** is the title of a folder prepared by the Medic-Alert Foundation, 1030 Sierra Drive, Turlock, Calif. for use by diabetics, epileptics, hemophiliacs and others with physical problems. The pamphlet gives information on the bracelets which are designed to prevent wrong medication being given to patients who may be unconscious.

For more details circle #767 on mailing card.

• How **Pinkerton Service** can save hospitals from losses is discussed in a 12-page booklet available from Pinkerton's, 154 Nassau St., New York 38. It discusses problems encountered by hospitals, listing them under internal thefts, personnel problems and security protection. Typical hospital cases are summarized and a list of user hospitals is included.

For more details circle #768 on mailing card.

• Two leaflets on **Hospital Type Grab Bars** and **Towel Rails and Grab Bars** are available from Logan Hospital Equipment Co., 136 N. Maryland, Glendale, Calif. **Bulletin No. 68** gives specifications on Hospital Type Grab Bars for hospitals, convalescent homes, sanitariums, nursing homes, chronic disease units, mental hospitals and others, with data on specially designed mounting plates. **Bulletin No. 57** gives factual information on extra heavy towel room rails and grab bars, with data on anchor plates and drawings of roughing-in details.

For more details circle #769 on mailing card.

• A handsomely-laid out and printed booklet on **Cadillac Commercial Cars and Chassis for 1959** is available from Cadillac Motor Car Div., General Motors Corp., Commercial Dept., Detroit 32, Mich. The special chassis, exclusively designed and engineered for ambulance use, are pictured and described with full specifications and illustrations of custom bodies built for the chassis.

For more details circle #770 on mailing card.

• **"Facts About Color Coding"** published by Becton, Dickinson & Co., Rutherford, N.J., explains color coding of hospital products to save time and labor. Lists are given of standard color codes adopted by manufacturers throughout the medical equipment industry.

For more details circle #771 on mailing card.

• The new **"Six Cylinder Cradle Bulk Oxygen Supply Unit"** developed by Ohio Chemical & Surgical Equipment Co., Madison 10, Wis. is described and illustrated in a brochure recently released. Specifications and installation data are included.

For more details circle #772 on mailing card.

• The extended payment plan for purchase of Vapor Drum Modulatic Boilers to conserve working capital is discussed in **Bulletin 486** available from Vapor Heating Corp., 80 E. Jackson Blvd., Chicago 4.

For more details circle #773 on mailing card.

Book Announcements

Brown, "Medical and Surgical Nursing II," 850 pgs., $8. Jamieson, Sewall and Gjertson, "Trends in Nursing History," 5th ed., 522 pgs., $5. Luder, Vernon and Zuffanti, "General Chemistry," 2nd ed., 582 pgs., $6.75. **W. B. Saunders Co., West Washington Square, Philadelphia 5, Pa.**

For more details circle #774 on mailing card.

Suppliers' News

Plans to merge the **A. S. Aloe Co., 1831 Olive St., St. Louis 3, Mo.**, hospital supply and equipment firm, and the **Brunswick-Balke-Collender Co., 623 S. Wabash Ave., Chicago 5,** manufacturer of furniture, are announced by **Howard F. Baer,** President of Aloe. The company will continue to operate as a separate institution with no change in policies, executives, employes, plants and manufacturing, according to Mr. Baer, and Aloe headquarters will remain in St. Louis. The report indicates that the proposed statutory merger would be effected by exchange of stock shares, with Aloe operating as a major division of Brunswick and both companies improving their long-range outlook. The merger plan will be submitted to stockholders of both companies at special meetings on June 26.

General Electric announces the establishment of a single communications organization for its several product businesses serving the medical markets and other communication equipment users. The new organization will be known as the **General Electric Communication Products Dept.** with headquarters in **Lynchburg, Va.** It will make two-way radio equipment for hospitals and doctors as well as closed circuit television equipment.

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Plate No. 1080

HOLY REDEEMER HOSPITAL
Bethayres, Penna.

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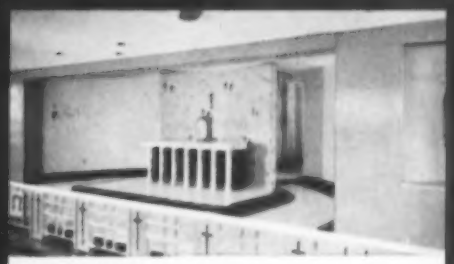

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Plate No. 1083

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MEMBERS: TILE COUNCIL OF AMERICA AND THE PRODUCERS' COUNCIL, INC.

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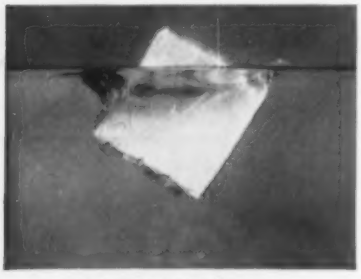
(MICROPULVERIZED MODIFIED STARCH LUBRICANT)

'WASH-PAK' is specifically designed to simplify the post-operative cleaning of surgical gloves. In order to facilitate drying and inspection and to prevent the gloves from sticking together while being processed add EZON to the final rinse water. EZON 'WASH-PAK' fulfills this function more conveniently than any other lubricant available. Pictures below show 'WASH-PAK''s time-saving advantages.

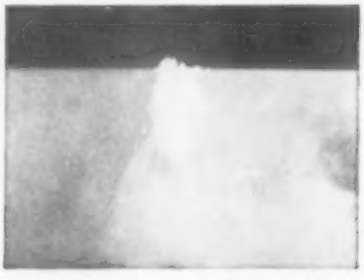


No Weighing

Just drop the EZON 'Wash-Pak' into the final rinse cycle and you're ready to go. No time-consuming weighing or measuring necessary. Each 'Wash-Pak' contains the exact amount of powder needed to condition 5 gallons of rinse water.

No Dusty Waste

Each EZON 'Wash-Pak' provides 4 ounces of micropulverized modified starch powder lubricant in a polyvinyl alcohol film pack. Dissolving rapidly in water, 'Wash-Paks' eliminate powder wastage, inaccurate measuring and starch dust in the air.



No Tedious Clean-Up

Put the lid back on the EZON 'Wash-Pak' can and you're all through. Each can contains 12 four ounce EZON 'Wash-Paks' . . . 12 cans to a case. Ask your purchasing agent to order a case today. Make your job simpler and cleaner. SR-812

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